

SEP 24 1940

No. 2
1-10-39
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29164

Registration District No. 592

Primary Registration District No. 4350

Registrar's No. 29

1. PLACE OF DEATH:
(a) County Montgomery
(b) City or town Montgomery
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME Henrietta Pogue
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Calvin Pogue 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 5/18/1867
(Month) (Day) (Year)

8. AGE: Years 73 Months 3 Days I If less than one day hr. _____ min.

9. Birthplace Near Troy Mo (City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER { 12. Name Dr Presley Gill
18. Birthplace Fairfax Va (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Mary Jane Brunke
15. Birthplace Troy Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Clarence Weeks
(b) Address Montgomery City Mo

17. (a) Burial (b) Date thereof 8/20/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Montgomery City Cem

18. (a) Signature of funeral director C. W. Hopkins
(b) Address Montgomery City Mo

19. (a) Aug 20, 40 (b) Bevill Wenzel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Montgomery
(c) City or town Montgomery (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19 th
year 1940 hour 8 am minute _____ M.

21. I hereby certify that I attended the deceased from July 21st 1936 to Aug 19 1940;
that I last saw her alive on Aug 19 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Hemorrhage with left Hemiplegia Duration 3 yrs
Due to Generalized Atherosclerosis Years
Due to Cholelithiasis 2 mos
Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
592 (Specify type of place)
While at work? _____ (e) Means of injury _____

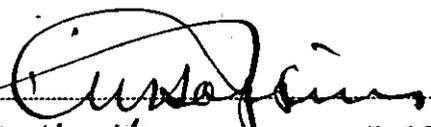
23. Signature E. T. Anderson (M.D. or other) M.D.
Address Montgomery City Date signed 8/19/40

WRITE PLAINLY - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....on the
19 th day of August 1940....., Registered Apprentice No.....
working under my personal supervision.

Signed.....


Licensed Embalmer No..... 1487.....

P. O. Address Montgomery City Mo.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.