

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **1585**  
**349**

BIRTH NO. _____		REG. DIST. NO. <b>149</b>		PRIMARY REG. DIST. NO. <b>1002</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City mo</b>		c. LENGTH OF STAY (In this place) <b>4 days</b>		c. CITY (If outside corporate limits, write RURAL and give township), <b>9150</b> <b>Rural Kansas City</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Lakeside Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>7321 Cherokee Drive</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Herbert</b>		b. (Middle) <b>John</b>		c. (Last) <b>Pogatschnick</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>1-19-1953</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>March 16 1900</b>	
9. AGE (In years last birthday) <b>52</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 4 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Branch manager - Stanley Home Products</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Albany Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Joseph Pogatschnick</b>		13b. MOTHER'S MAIDEN NAME <b>Bertha Bartholdi</b>		14. NAME OF HUSBAND OR WIFE <b>Ella Pogatschnick</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none 472-28-3193</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Ella Pogatschnick</b>		ADDRESS <b>7321 Cherokee Dr</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Antenatal leukemia</b>				<b>5 yrs.</b>	
		DUE TO (c) <b>Hypertension</b>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<b>4201</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>August 19, 1952</b> to <b>Jan 19, 1953</b> that I last saw the deceased alive on <b>Jan 19, 1953</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.							
23a. SIGNATURE <b>Geo. F. Clark</b>				23b. ADDRESS <b>7329 Broadway</b>		23c. DATE SIGNED <b>1-20-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>1-21-1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>-</b>		24d. LOCATION (City, town, or county) (State) <b>Duluth, Minnesota</b>	
DATE REC'D BY LOCAL REG. <b>1-20-53</b>		REGISTRAR'S SIGNATURE <b>Steraldine Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>France Wernall Funeral Home</b>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Russell M. Lane*.....

Licensed Embalmer No. *4255*.....

P. O. Address *H. C. M.*.....

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, fact should be so stated above.