

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 14 1953

BIRTH NO.		REG. DIST. NO. 116	PRIMARY REG. DIST. NO. 3020	Registrar's No. 207
1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: name and date of admission) a. STATE Missouri b. COUNTY Franklin		
b. CITY (If outside corporate limits, write RURAL and give township) Washington	c. LENGTH OF STAY (In this place) 25 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) Washington		
d. FULL NAME OF HOSPITAL OR INSTITUTION 701 West 2nd St.		d. STREET ADDRESS (If rural, give location) 701 West 2nd		
3. NAME OF DECEASED (Type or Print)	a. (First) WILLIAM	b. (Middle) FRANK	c. (Last) PUES	4. DATE OF DEATH (Month) (Day) (Year) 12 8 1953
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1-15-1892	9. AGE (In years last birthday) IF UNDER 1 YEAR 61 Months 10 Days 23 IF UNDER 1 MRS. Hours 0 Mins. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Phone Repair	10b. KIND OF BUSINESS OR INDUSTRY General Store	11. BIRTHPLACE (City and State of Foreign Country) Cincinnati Ohio		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Frank Poes	13b. MOTHER'S MAIDEN NAME Katharine Ringer	14. NAME OF HUSBAND OR WIFE Debraud		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If specify war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Walter Poes		ADDRESS Warren, Missouri
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) Hypostatic pneumonia ANTECEDENT CAUSES DUE TO (b) Generalized debility DUE TO (c) Old cerebral hemorrhage II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic C.V. Disease			INTERVAL BETWEEN ONSET AND DEATH 5 days 3 yrs 3 yrs. ? years.
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None		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) 331X		
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 4 April, 1951 , to 8 Dec , 1953, that I last saw the deceased alive on 8 Dec , 1953, and that death occurred at 6:30 P.M. , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) Raymond J. Boggo, M.D.		23b. ADDRESS Washington, Mo.		23c. DATE SIGNED 9 Dec 53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-11-1953	24c. NAME OF CEMETERY OR CREMATORY St. Francis Bogia Cemetery	24d. LOCATION (City, town, or county) (State) Washington Missouri	
DATE REC'D BY LOCAL REG. 12/10/53	REGISTRAR'S SIGNATURE H. H. Hedeman	99-0 H. H. Hedeman	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles F. H. by McWilliams Washington, Mo.	

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 *W. W. Wilbur*

Licensed Embalmer No. 4511

P. O. Address Washington, Missouri

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.