

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 6 - 1957

State File No. **12522**

BIRTH NO. _____ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 8288 Registrar's No. 31

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>CLAY</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u> | |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>RURAL, EXCELSIOR SPRINGS,</u> | c. LENGTH OF STAY (in this place) _____ | c. CITY OR TOWN <u>EXCELSIOR, MO.</u> | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>RR #1, TWO MILES N. OF EX. SPRS.</u> | | STREET ADDRESS (If rural, give location) <u>600/0</u> | |

| | | | | | |
|---|-------------------|-----------------------|---|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>JOSE</u> | b. (Middle) _____ | c. (Last) <u>POGA</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 1, 1957</u> | | |
|---|-------------------|-----------------------|---|--|--|

| | | | | | | |
|--|-------------------------------|---|---|--|---|---|
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>UNKNOWN</u> | 8. DATE OF BIRTH <u>UNKNOWN</u> | 9. AGE (In years last birthday) <u>UNKNOWN</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>UNKNOWN</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>UNKNOWN</u> | |

| | | |
|-----------------------------------|--|--|
| 13a. FATHER'S NAME <u>UNKNOWN</u> | 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | 14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</u> |
|-----------------------------------|--|--|

| | | |
|---|--|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u> | 16. SOCIAL SECURITY NO. <u>554-24-7590</u> | 17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____ |
|---|--|---|

| | | | |
|---|--|--|----------------------------------|
| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Unknown</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Possible Acute Coronary Occlusion</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|----------------------------------|

| | | |
|------------------------------|--|--|
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION _____ | 20. AUTOPSY? <u>2</u> 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) (Min.) _____ | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? _____ |

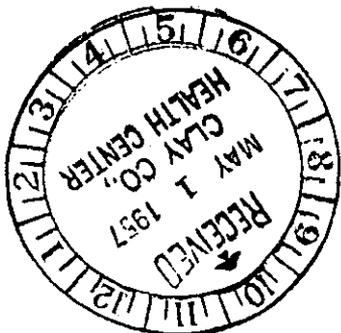
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

| | | |
|---|--|--------------------------------|
| 23a. SIGNATURE <u>D. L. Pate M.D.</u> (Degree or title) _____ | 23b. ADDRESS <u>North Kansas City Mo</u> | 23c. DATE SIGNED <u>4/1/57</u> |
|---|--|--------------------------------|

| | | | |
|---|---|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24b. DATE <u>APRIL 5, 1957</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>CROWN HILLS</u> | 24d. LOCATION (City, town, or county) (State) <u>EXCELSIOR SPRINGS, MO</u> |
| DATE REC'D BY LOCAL REG. <u>4/30/57</u> | REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u> | 25. FUNERAL HOME, INC. ADDRESS <u>Excelsior Springs, Missouri</u> | |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

62-0



MAY 8 1957

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.....
Signature of Student Embalmer

Signed *Ralph VanLandingham*
Licensed Embalmer No. 4009
Galena Springs, Ill.
P. O. Address

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.