

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

6334

1. PLACE OF DEATH
 County St. Louis Registration District No. 1170
 Township St. Louis Primary Registration District No. 6248 W
 City St. Louis - McRichmond Heights (No. St. Marys Hospital) St. _____ Ward _____
 Registered No. 39

2. FULL NAME David F. Bogard
 (a) Residence. No. 6045 Horton Pl. St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 5-1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
62 10 12

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Night Watchman
 (b) General nature of industry, business, or establishment in which employed (or employer) Wagner Electric
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

10. NAME OF FATHER James Bogard

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Illinois

12. MAIDEN NAME OF MOTHER Lydia McCullen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Illinois

14. INFORMANT John Bogard
 (Address) 3522 Papin St

15. FILED 2/18 19 28 B. L. Jensen
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 17 19 28

17. I HEREBY CERTIFY That I attended deceased from Feb 11, 19 28, to Feb 17, 19 28 that I last saw him not alive on Feb 18, 19 28, and that death occurred, on the date stated above, at 11:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho pneumonia
131
16/18
10/13 (duration) _____ yrs. _____ mos. 4 ds.
 CONTRIBUTORY (SECONDARY) chronic bronchitis and nephritis (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? 129 W
 IF NOT AT PLACE OF DEATH? _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Usual
 (Signed) J. O. Morris M. D.
 , 19 (Address) 11949 Nodanmont

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Valhalla Cemetery DATE OF BURIAL Feb 20 19 28

20. UNDERTAKER E. J. Schmur ADDRESS 3125 Lafayette av

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

