

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

Do not use this space.

17805

1. PLACE OF DEATH

County Marion
Township Marion
City Hannibal

Registration District No. 547
Primary Registration District No. 3079

File No. _____
Registered No. 138
St. _____ Ward _____

2. FULL NAME Emma Lillian Ogburn

(a) Residence. No. 719 Oak St. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wale C. Ogburn

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 16 - 1908

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
20 | 3 | 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Ralls Co
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Waring P. Hickman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Monroe Co Mo

12. MAIDEN NAME OF MOTHER Gynthia R. Della

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Monroe Co Mo

14. INFORMANT (Address) Waring P. Hickman
Monroe City Mo R # 2

15. FILED 576 78 E E Strole
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 24 1928

17. I HEREBY CERTIFY That I attended deceased from 5/21 1928, to 5-24 1928, that I last saw him alive on 5-24 1928, and that death occurred, on the date stated above, at 3:45 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia
121/14
129 117
152 B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Septicemia
large abscess (duration) yrs. mos. ds. 6

18. WHERE WAS DISEASE CONTRACTED her home
IF NOT AT PLACE OF DEATH _____

1. DID AN OPERATION PRECEDE DEATH yes DATE OF 5-21-28

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J J Bauer, M. D.

5726 1928 (Address) Hannibal Mo

*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 Monroe City Mo DATE OF BURIAL May 26 1928

Remans Chapel Cemetery

20. UNDERTAKER Wilson & Son ADDRESS Monroe City Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state to extremely sufficient. Do not use this space.

1928

500

