

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

Do not use this space.

19549

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis Mo** (No. **Mo Baptist Hosp**) St. Ward)

File No.
 Registered No. **5506**

2. FULL NAME *Calvin H. Ogle*

(a) Residence. No. *2171 Brashear Ave* St., *12* Ward. *Pure Laver Mo*
 (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) *Widower*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 21 - 1858*

| 7. AGE | YEARS | MONTHS | DAY | IF LESS than 1 day, hrs. or min. |
|--------|-----------|----------|-----------|--|
| | <i>72</i> | <i>6</i> | <i>18</i> | |

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Fireman 311*
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer *Laclede Gas Co*

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY) *Ohio 2.*

PARENTS
 10. NAME OF FATHER *Eli Ogle*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Ohio*
 12. MAIDEN NAME OF MOTHER *Unknown*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Ohio*

14. INFORMANT *Albert Ogle*
 (Address) *2171 Brashear Ave*

15. M. V. FILED *12 1931* *May 10 1931* REGISTERED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 9 1931*

17. I HEREBY CERTIFY, That I attended deceased from *Mar 5* 1931, to *May 9* 1931, and that I last saw him alive on *May 9* 1931, and that death occurred, on the date stated above, at *6 P. M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Interstitial nephritis. Chronic

1931
 (duration) yrs. *2* mos. ds.
 CONTRIBUTORY (SECONDARY) *131*
 (duration) yrs. mos. ds.

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

0 DID AN OPERATION PRECEDE DEATH? *NO* DATE OF.....
 WAS THERE AN AUTOPSY? *NO*

WHAT TEST CONFIRMED DIAGNOSIS *Physical examination*
 (Signed) *M. D. Jennings*, M. D.
May 11 1931 (Address) *4101 Washington Blvd*

*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* DATE OF BURIAL *May 12 1931*

20. UNDERTAKER *Lambert Trust Co* ADDRESS *4234*

N. B.—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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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