

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.

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

SEP 14 1939

27362
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
 (b) Township..... Primary Registration District No. **1003** Registered No. **6862**
 or **St. Louis, Mo.**
 (c) City..... (d) Street No. *City Infirmary* St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *263* **Alvira Bogardus**

(a) Residence, No. **5800 Arsenal St.** St. **13** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow.		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) November 19, 1852				
7. AGE YEARS 86	MONTHS 7	DAYS 24	If LESS than 1 day, hrs. or min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Seamstress			
	9. Industry or business in which work was done, as saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York.				
FATHER	13. NAME Unknown			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) "			
MOTHER	15. MAIDEN NAME "			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) "			
17. INFORMANT (ADDRESS) E. Molony, 5800 Arsenal St.				
18. BURIAL, CREMATION, OR REMOVAL PLACE City Crematory 8-7-39				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) City Infirmary				
20. FILED AUG 7 1939 <i>J. Bredich</i> Local Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **July 13, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **July 16, 1928** to **July 13, 1939**
 I last saw her alive on **July 13, 1939**. Death is said to have occurred on the date stated above, at **12:00** M.
 The principal cause of death and related causes of importance were as follows:
Chronic suppurative
Septicemia
Atherosclerosis

Other contributory causes of importance:
Septicemia
Atherosclerosis

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....
 (Signed) *E. Molony*, M. D.
 (Address) *5800 Arsenal St.*

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.