

APR 22 1940

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

10762
Do not use this space.

1. PLACE OF DEATH

(a) County Crawford Registration District No. 231
(b) Township Meramec Primary Registration District No. 5314 Registered No. _____
(c) City _____ or _____ (d) Street No. _____ 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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Louis Washington Ogle

(a) Residence, No. _____ St. (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 M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sofia Ogle
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 8 - 1855
7. AGE YEARS 84 MONTHS 8 DAYS 23 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. None
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 97

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Crawford Co. Missouri

FATHER
13. NAME Louis Ogle

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER
15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) Corbett Ogle
2418 Madison Ave. Granite City, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Louis DATE 4/2 - 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) L. J. ...
St. Louis, Mo.

20. FILED 4-8 1940 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 1, 1940

22. I HEREBY CERTIFY That I attended deceased from July, 1939, to April 1, 1940
I last saw h alive on March 30, 1940 Death is said to have occurred on the date stated above, at 1:30 P.M.
The principal cause of death and related causes of importance were as follows:

Longum Post S. Date of onset 4-1-25
97

Other contributory causes of importance: Arterio Sclerosis 1939

Name of operation _____ Date of _____
What test confirmed diagnosis? Tubercular Was there an autopsy? N

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? No
If so, specify _____
(Signed) William H. ..., M. D.
St. Joins, Mo
217 (Address)

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

MARGIN RESERVED FOR BINDING

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

V. S. NO. 2
50M-9-19-38
I X16805

EMBALMENT
STATE OF MARYLAND
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
Baltimore, Md.

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.....

R. L. Jones, Registered Apprentice No.
working under my personal supervision.

RECEIVED

District Health Officer No. 5,

District File Number 440-108

Date Filed 9/1/40

Signed R. L. Jones

Licensed Embalmer No. 2379

P. O. Address Steeleville Md

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10762

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 231

Primary Registration District No. 2314

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Crawford

(b) City or town Meramec rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Louis Washington Ayle

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 84 Months 8 Days 28 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

{ 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

{ 14. Maiden name _____

{ 15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-8-40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford

(c) City or town Rural
(If outside city or town limits write "RURAL")

(d) Street No. Meramec
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month apr day 1
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
_____ (Specify type of place) _____ (e) Means of injury _____

23. Signature Wm H. Brewer (M. D. or other) _____
Address St James _____

Duration _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

5-10762

1940