

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24330

State File No.

2940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: General Hospital #2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: 6-9-40-6-20-40
 In this community 6 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Ben Bogan 250

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife -- 6. (c) Age of husband or wife if alive 1 years

7. Birth date of deceased 3 1 1881
 (Month) (Day) (Year)

8. AGE: Years 59 Months 3 Days 19 If less than one day hr. min.

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

10. Usual occupation none

11. Industry or business 1

12. Name Willis Bogan 1

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

14. Maiden name Suzanna Reese
 (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Record Clerk
 (b) Address General Hospital #2

17. (a) Burial (b) Date thereof July 24, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Deeds

18. (a) Signature of funeral director Wm. A. G. ...
 (b) Address City

19. (a) 7-23, 1940 (b) M. M. ...
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

0 Mo. (a) State Mo. (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 523 Grand Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 20
 year 40 hour 12 minute A. M.

21. I hereby certify that I attended the deceased from 6-9-, 1940 to 6-20, 1940
 that I last saw him alive on 6-20-, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy Duration _____

Due to Hypertensive Type of Heart Disease.

Due to 9/5/40

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?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. A. G. ... (M. D. or other) _____
 Address Gen. Hosp. #2. Date signed 6-20-

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.

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

L. J. Harris
.....
Licensed Embalmer No. 3388

P. O. Address K. C. Mo.

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.