

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

33980

Registrar's No.

8677

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town Saint Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4061 West Belle Place
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____ Life
years, months or days)

3. (a) PRINT FULL NAME Emily Bogy

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Frank Jacob Bogy 6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased March 21st, 1883
(Month) (Day) (Year)

8. AGE: Years 57 Months 6 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Saint Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER { 12. Name Lewis Jones
13. Birthplace Saint Louis Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Emily Baker
15. Birthplace Eastern Shore, Maryland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank Jacob Bogy
(b) Address 4061 West Belle Place

17. (a) Burial (b) Date thereof 10-23-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Charles J. Davis
(b) Address 4107-09 Finney Avenue

19. (a) Oct 21 1940 (b) J. F. Budich
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town Saint Louis 11
(If outside city or town limits, write "RURAL")
(d) Street No. 4061 West Belle Place
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 20th
year 1940 hour 5:20 minute _____ P. M.

21. I hereby certify that I attended the deceased from 10th Dec 39
6 to 20th Oct 1940 to October 20th, 1940
that I last saw her alive on October 20th, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death acute insufficiency Duration _____

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) Means of injury _____

23. Signature W. J. Leaton (M. D. or other)
Address 2743 Franklin Avenue Date signed _____

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

working under my personal supervision.

Registered Apprentice No.

265

Signed

Licensed Embalmer No.

3522

P. O. Address 4107 Finney Avenue

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.