

Dr. Bruce

Registration District No. 213

Primary Registration District No. 3014

State File No. \_\_\_\_\_

Registrar's No. 111

1. PLACE OF DEATH:

(a) County Cole  
 (b) City or town Jefferson City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Mary's Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 32 days  
(Specify whether years, months or days)  
 In this community 24 years

3. (a) PRINT FULL NAME Mildred Ann Ogden

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 1850  
(Month) (Day) (Year)

8. AGE: Years 91 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Bedford County, Va  
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

12. Name William Ogden

13. Birthplace Waugh Station, Va  
(City, town, or county) (State or foreign country)

14. Maiden name Susan Rucker

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

16. (a) Informant Arnold B Ogden  
 (b) Address Jefferson City, Mo

17. (a) Burial (b) Date thereof Apr-5-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marksville, Missouri

18. (a) Signature of funeral director Thos G. Gador

(b) Address Jefferson City, Missouri

19. (a) 4-4-31 (b) D. H. ...  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole  
 (c) City or town Jefferson City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 224 East Dunklin Street  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2nd  
 year 1941 hour 7:30 minute P M.

21. I hereby certify that I attended the deceased from 1st to April 2nd, 1941  
 that I last saw him alive on April 2nd, 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death 6 grams of uremia & bladder

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions Fracture left hip (pathologic)  
(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 J. Bruce (M. D. or other) MD  
 Address Jefferson City, Mo Date signed 4/4/41

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

MOTHER FATHER

45

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

*Joseph J. Gordon*

Licensed Embalmer No. *1286*

P. O. Address *Jefferson City, 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, fact should be so stated above.

REV. C. H. ...

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 14310

Registration District No. C 213

Primary Registration District No. 3014

Registrar's No. \_\_\_\_\_

WRITE PLAINLY - USE UNFADING BLACK INK - MAKE PERMANENT RECORD  
KAWENA MOORE

1. PLACE OF DEATH

(a) County Cole  
(b) City or town Jefferson city  
(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 Mildred Ann Ogden

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, divorced, married S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

8. AGE: Years 91 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ 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) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month apr day 2  
year \_\_\_\_\_ 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 Carcinoma uterus + bladder Distention

Due to Primary in utero

Due to 45 yr

Other conditions fracture left hip  
(Include pregnancy within 5 months of death) (Pathologic)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 Pathologic fracture

(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 J. G. Bruce (M. D. or other) M.D.

Address Jefferson City Mo Date signed 4/2/41

SUPPLEMENTARY

S-14310