

Form No. 2
M-2-43
5-17-39
X3557

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13763

FILED MAY 3 1948

State File No. _____

Registrar's No. 398

Registration District No. 42

Primary Registration District No. 1005

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

1. PLACE OF DEATH:
Buchanan
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution one week
In this community 8 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Anna Ogle
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female
5. Color or race white
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Charles A. Ogle
6. (c) Age of husband or wife if alive Dead 8 years
7. Birth date of deceased July 8, 1885 (Month) (Day) (Year)

8. AGE: Years 57 Months 8 Days 26
If less than one day hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business Home

12. Name William Spray

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

14. Maiden name Nancy Rich (City, town, or county) (State or foreign country)

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

16. (a) Informant Charles Ogle (Son)
(b) Address U.S. Army, California

17. (a) Burial (Burial, cremation, or removal)
(b) Date thereof 4/6/43 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director John E. [Signature]
(b) Address 6054 [Address]

19. (a) 4-6-43 (Date received local registrar)
(b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
Missouri Buchanan
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(d) Street No. 6207 Washington St. (If outside city or town limits, write "RURAL")
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 4th
year 1943 hour 2: minute 30 A.M.
21. I hereby certify that I attended the deceased from March 29 1943 to April 4 1943
that I last saw him alive on April 3 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage
Due to: Hypertension
Due to: Nephritis
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 [Signature] (M. D. or other) M.D.
Address Welfare Board
Date signed 4/5/43

Duration
Physician
Underline the cause to which death should be charged statistically.

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.....

Signed *John E. Rupp*.....

Licensed Embalmer No. *3986*.....

P. O. Address *St Joseph, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13763
Registrar's No. 398

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: mo. meth. hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 wk (Specify whether years, months or days) 8 yrs

3. (a) PRINT FULL NAME Anna Ugle

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased July 8 - 1885
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry of 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 _____
(Burial, cremation, or removal) (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 Mo (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 6207 Wash. St.
(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 4 Year 1943 hour 3 minute 00 M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: cerebral hemorrhage, 6 d.
Hypertension
chronic nephritis
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? _____

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

23. Signature [Signature] (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

