

No. 2  
5-43  
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X36871

FILED JAN 11 1945

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 427

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

1. PLACE OF DEATH:

(a) County Pettis  
(b) City or town Sedalia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
205 E. COOPER  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1  
In this community about 84 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 80  
(c) City or town Pettis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 205 E Cooper  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country U

3. (a) PRINT FULL NAME SARAH OGDEN

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

4. Sex F 5. Color or race Negro 6. (a) Single, widowed, married, divorced 2  
6. (b) Name of husband or wife Will Ogden 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years about 84 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9: Birthplace Sedalia Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Cook

11. Industry or business

12. Name Unknown  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Banajah Caldwell  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Arthur Dumbles  
(b) Address Sedalia Mo  
17. (a) Burial (b) Date thereof 1-1-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Sedalia Mo

18. (a) Signature of funeral director F. D. Ferguson  
(b) Address Sedalia  
19. (a) 1-1-45 (b) Ms Anna Berger  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24<sup>TH</sup> year 1944 hour \_\_\_\_\_ minute 19 M.  
21. I hereby certify that I attended the deceased from May 1<sup>st</sup> to Dec 24, 1944  
that I last saw h. or alive on Dec 24, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death chronic Interstitial Nephritis  
Due to Arterio - Sclerosis

Other conditions (Include pregnancy within 3 months of death)

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 \_\_\_\_\_  
(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) (c) Means of injury \_\_\_\_\_  
23. Signature A. R. Malloy (M. D. or other) M.D.  
Address 116 Gul. Main Date signed 1-1-45

1022

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**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..... *F. D. Ferguson* .....

Licensed Embalmer No. *2172* .....

P. O. Address..... *Sedalia* .....

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan  
Registrar's No. 427

Registration District No. 274

Primary Registration District No. 2052

1. PLACE OF DEATH: Pettis  
(a) County  
(b) City or town Sedalia  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah Ogden  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 24  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex F 5. Color or race B  
6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Wolfe 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)  
8. AGE: Years 84 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day, \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
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)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) \_\_\_\_\_  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-41843

1944