

V. S. No. 2
00M-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4666

FILED MAR 3 1945

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 1470

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4189 Delmar 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None
(Specify whether years, months or days)

In this community 20 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 9 12

(d) Street No. 4189 Delmar
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Roscoe T Oglesby

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex M 5. Color or race W

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 Sep 24 1891
(Month) (Day) (Year)

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

53 4 18 hr. min.

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

10. Usual occupation Carpenter

11. Industry or business Retired

MOTHER FATHER

12. Name John Oglesby

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

14. Maiden name Sarah Farmer

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

16. (a) Informant Edna Green

(b) Address 4189 Delmar

17. (a) Ship (b) Date thereof 2/14/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mayfield Kentucky

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Ave.

19. (a) FEB 14 1945 (b) J. F. Prudeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 12
year 45 hour 11 minute 50-P M.

21. I hereby certify that I attended the deceased from morning
15:00 184 to Feb 12 1945
that I last saw him alive on Feb 12 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Pulmonary Tuberculosis
Enlarged

Duration
10 yrs

Due to _____

Due to _____

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)
(e) Means of injury smk
23. Signature Clyde G. Kane (M. D. or other) smk
Address 706 Wallon Date signed 2/14/45

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..... *L.R. Casper*

Licensed Embalmer No. *3633*

P. O. Address. *2317 Lafayette*

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.