

STANDARD CERTIFICATE OF DEATH

State File No. **23718**

Registrar's No. **799**

FILED OCT 27 1945

28

Primary Registration District No. **2000**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **O'Reilly General Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 yrs, 2 mos, 26 da**
In this community **2 yrs, 2 mos, 26 days** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Nebraska** (b) County **Da was 911**
(c) City or town **Chadron**
(If outside city or town limits, write "RURAL")
(d) Street No. **- -**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **CLYDE F. COGDILL**

3. (b) If veteran, name war **WORLD WAR II** 3. (c) Social Security No. **UNK-**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive **77** years

7. Birth date of deceased **September 28, 1910**
(Month) (Day) (Year)

8. AGE: Years **35** Months **0** Days **10** If less than one day hr. min.

9. Birthplace **Chadron Nebraska**
(City, town, or county) (State or foreign country)

10. Usual occupation **Grocery Clerk**

11. Industry or business **Grocer**

12. Name **Homer Cogdill**

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

14. Maiden name **Alida (Unknown)**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **WD, AGO Form 24**

(b) Address **O'Reilly Gen. Hosp, Sped, Mo**

17. (a) **Removal** (b) Date thereof **October 9, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chadron, Nebraska**

18. (a) Signature of funeral director **Almond [Signature]**

(b) Address **Springfield, Mo**

19. (a) **10-8-45** (b) **W. H. Handley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **7**
year **1945** hour **8** minute **10** A.M.

21. I hereby certify that I attended the deceased from **10 July** 19**44** to **7 October** 19**45**;
that I last saw him alive on **6 October** 19**45**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary embolism** Duration _____

Due to **Maxilla facial surgery (bone graft to mandible)** 3 days

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

Major findings: Of operations **11/10** Of autopsy **Findings incomplete** 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) _____ Date of occurrence _____
(b) 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? _____

23. Signature **C. T. Killeen** (M. D. or other) **MD**
Address **Shelby Co. Mo** Date signed **7 Oct 45**
Name at work? (Specify type of place) (e) Means of injury _____

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

MOTHER FATHER

37
2
6

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. A. Raub

Licensed Embalmer No. 3084

P. O. Address Springfield, 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.