

FILED NOV 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33631**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5466** Registrar's No. **931**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE Missouri b. COUNTY Dallas	
b. CITY (If outside corporate limits, write RURAL and give township) Rural - South Campbell Twp.		c. CITY (If outside corporate limits, write RURAL and give township) Urban	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) /	
d. FULL NAME OF HOSPITAL OR INSTITUTION OZARK OSTEOPATHIC HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) Gordon b. (Middle) Dee c. (Last) Hogfer	4. DATE OF DEATH (Month) (Day) (Year) 10-23-49
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5. SEX male	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH 10-7-37	9. AGE (in years last birthday) 12	IF UNDER 1 YEAR Months 6	IF UNDER 1 Wks. Days 6	IF UNDER 1 Hrs. Hours 6	IF UNDER 1 Min. Min.
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10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Child	10b. KIND OF BUSINESS OR INDUSTRY Child	11. BIRTHPLACE (State or foreign country) Glenn, Calif.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Chester R. Hogfer	13b. MOTHER'S MAIDEN NAME Aline Williams	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Chester Hogfer	ADDRESS Urban, Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tracheo Bronchitis		24 hours
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Acute enteritis DUE TO (c) _____		3 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Cardiac failure (anti)		501X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **10-19-1949** to **10-23, 1949**, that I last saw the deceased alive on **10-20, 1949**, and that death occurred at **7:35 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE C. H. Bailes	(Degree or title) Mo 2	23b. ADDRESS Urban, Mo	23c. DATE SIGNED 10-23-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-25-49	24c. NAME OF CEMETERY OR CREMATORY Bowers Chapel Cem	24d. LOCATION (City, town, or county) (State) Urban, Mo
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DATE REC'D BY LOCAL REG 10-24-49	REGISTRAR'S SIGNATURE W. E. Handley	111	25. FUNERAL DIRECTOR'S SIGNATURE W. Vaughan Ream	ADDRESS Urban, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Allen W. Vaughan*

Licensed Embalmer No. *4156*

P. O. Address *Urban, 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.