

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

5773

State File No.

No. 300
10.48

FILED FEB 23 1950

BIRTH NO. _____ REG. DIST. NO. 292 PRIMARY REG. DIST. NO. 6001 Registrar's No. 5

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY Ralls	b. CITY (If outside corporate limits, write RURAL and give township) Spalding	a. STATE Missouri	b. COUNTY Ralls
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) Spalding	
d. FULL NAME OF HOSPITAL OR INSTITUTION Residence Spalding		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED			4. DATE OF DEATH		
a. (First) Samuel	b. (Middle) Martin	c. (Last) Bogue	(Month) February	(Day) 13,	(Year) 1950
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH September 25, 1877		9. AGE (In years last birthday) 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY XXX	11. BIRTHPLACE (State or foreign country) Ralls County Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Samuel Watson Bogue	13b. MOTHER'S MAIDEN NAME Barbara Gustin	14. NAME OF HUSBAND OR WIFE Cora Jane Bogue
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 Walter Bogue Spalding
		ADDRESS Missouri

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 4 days 1 year 4 1/2 22
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis Acute		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocarditis Chronic DUE TO (c) unknown		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. unknown			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION None	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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) Ralls Mo.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-14, 1949, to 2-13, 1950, that I last saw the deceased alive on 2-13, 1950, and that death occurred at 8:55 P.m., from the causes and on the date stated above.

23a. SIGNATURE <i>C. H. Brooks</i>	(Degree or title) 100.	23b. ADDRESS Center, Mo	23c. DATE SIGNED 2-15-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2/16/50	24c. NAME OF CEMETERY OR CREMATORY Middleton	24d. LOCATION (City, town, or county) (State) Montgomery County Missouri
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DATE REC'D BY LOCAL REG. 2/15/50	REGISTRAR'S SIGNATURE <i>L. D. D. ...</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>W. ...</i>	ADDRESS Hannibal Missouri
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

890
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RECEIVED FEB 2
District Health Officer
District File Number 2-30
Date Filed FEB 20 1

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.

Signed.....

John S. Spard

Signed.....

Student Embalmer

Licensed Embalmer No. 4560

P. O. Address Hannibal Missouri

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.