

FILED APR 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8104
Registrar's No. 277

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Springfield 0346	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital		d. STREET ADDRESS (If rural, give location) 709 E. Dale U	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) C. c. (Last) Ogden		4. DATE OF DEATH (Month) (Day) (Year) March 25 1951	
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 25-1871	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Month Days	IF UNDER 12 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Railroad Worker-Frisco R.R.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Canada 2		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Chas. L. Ogden		13b. MOTHER'S MAIDEN NAME Margaret Campbell		14. NAME OF HUSBAND OR WIFE Clare Ogden	
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15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT'S SIGNATURE OR NAME Mrs. Alpha King Lebenen, Mo.		ADDRESS	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-Renal-Vascular Disease				INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) _____					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				442X	

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)		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 **MARCH**, 1944, to **3-25**, 1951, that I last saw the deceased alive on **3-25**, 1951, and that death occurred at **4:00 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE <i>W. E. Handley</i>		(Degree or title) M.D.		23b. ADDRESS Springfield, Mo.		23c. DATE SIGNED 3-27-51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-28-51		24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		24d. LOCATION (City, town, or county) (State) Springfield, Missouri	
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DATE REC'D BY LOCAL REG. 3-27-51		REGISTRAR'S SIGNATURE <i>W. E. Handley</i>		25. FUNERAL DIRECTOR'S SIGNATURE J. W. Klingner & Co.		ADDRESS Springfield	
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(Licensed Embalmer's Statement on Reverse Side)

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

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APR 4 1951

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 _____

working under my personal supervision.

Student Embalmer No. _____

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.