

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

45008

State File No. \_\_\_\_\_

FILED JAN 26 1953

318

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12119

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____					
1. PLACE OF DEATH a. CITY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis				b. COUNTY Missouri							
c. LENGTH OF STAY (In this place)				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis							
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 3862 Page							
3. NAME OF DECEASED (Type or Print)			a. (First) William			b. (Middle) Ogden					
c. (Last)			4. DATE OF DEATH			(Month) (Day) (Year)					
5. SEX Male 2			6. COLOR OR RACE Negro			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Separated 1					
8. DATE OF BIRTH November 5, 1907			9. AGE (In years last birthday) 45			10. IF UNDER 1 YEAR Months 1 Days 24					
11. BIRTHPLACE (City and State or Foreign Country) New Madrid, Missouri 0			12. CITIZEN OF WHAT COUNTRY? USA			13a. FATHER'S NAME Dan Ogden					
13b. MOTHER'S MAIDEN NAME Bell Pettie			14. NAME OF HUSBAND OR WIFE Hester Ogden			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					
16. SOCIAL SECURITY NO. ?			17. INFORMANT'S SIGNATURE OR NAME Nellie Johnson			ADDRESS 802 N. Leffingwell					
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) Cerebral Thrombosis				INTERVAL BETWEEN ONSET AND DEATH Undet.			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) Hypertensive Cardiovascular Disease				Undet.			
DUE TO (c) Undetermined				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)			
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? 443X			
22. I hereby certify that I attended the deceased from 12-25, 19 52, to 12-29, 19 52, that I last saw the deceased alive on 12-29, 19 52, and that death occurred at 10:05pm., from the causes and on the date stated above.											
23a. SIGNATURE Edward B. Williams, M.D.						23b. ADDRESS 2601 N Whittier St			23c. DATE SIGNED 12-31-52		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 0				24b. DATE Jan. 2, 1953		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery				24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
DATE REC'D BY LOCAL REG. JAN 2 1953				REGISTRAR'S SIGNATURE [Signature]				25. SUPERVISOR'S SIGNATURE [Signature] ADDRESS 1221 N. Grand Blvd.			

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 Gupton Luan  
Licensed Embalmer No. 4580

P. O. Address 1221 N Grand

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.