

FILED FEB 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3938**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **157**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
c. LENGTH OF STAY (in this place) 42 yrs		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Rathburn Nursing Home		f. STREET ADDRESS (If rural, give location) 901 South 15th Street	
e. (If not in hospital or institution, give street address or location) 1008 Church St.		01170	

3. NAME OF DECEASED (Type or Print) a. (First) ANNIE b. (Middle) MARY c. (Last) BOGARD			4. DATE OF DEATH (Month) (Day) (Year) JANUARY 26, 1955		
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH May 10, 1870		9. AGE (In years last birthday) 84		IF UNDER 1 YEAR: Months _____ Days _____	
IF UNDER 24 HRS: Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (City and State or Foreign Country) Gower, Missouri			12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME John A. Deakins		13b. MOTHER'S MAIDEN NAME Eliza Kinnard		14. NAME OF HUSBAND OR WIFE George	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS George Bogard, 901 So. 15th St., St. Joseph,	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart failure		Mo. INTERVAL BETWEEN ONSET AND DEATH 4-5 weeks	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Parkinson's Disease		DUPLICATE CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis		several yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4200		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)	
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?	

22. I hereby certify that I attended the deceased from **Sept 7, 1951**, to **Jan 26, 1955**, that I last saw the deceased alive on **about Dec 15, 1954**, and that death occurred at **10:40P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Lucia M. Ide M.D.		23b. ADDRESS 902 Edmond St., St. Joseph, Mo.		23c. DATE SIGNED 2-12-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE Feb 1, 1955		24c. NAME OF CEMETERY OR CREMATORY Allen Cemetery	
24d. LOCATION (City, town, or county) (State) Gower, Missouri					

DATE REC'D BY LOCAL REG. Feb 14, 1955		REGISTRAR'S SIGNATURE Kathleen M. Allison		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Heston - Bowman St. Joseph, 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.....
Signature of Student Embalmer

Signed *Eugene Wood*.....

Licensed Embalmer No. *3800*

P. O. Address *319 S. 10th, N. D.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.