

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-019503
STATE FILE NUMBER 4753

Health,
& Welfare
Public
Service

FILED MAY 19 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 4753

S. 300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Clayton</u> <u>44520</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hospital</u>		Length of stay in 1b <u>0</u>	d. STREET ADDRESS (If outside, give location) <u>7625 Shirley Drive</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR RAYMOND BOGAN, JR.</u>			4. DATE OF DEATH Month Day Year <u>May 3rd, 1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25th, 1905</u>	9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>5 8</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Sales Mgr. - Be-Mac Transport Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dallas, Texas</u>	11. BIRTHPLACE (City and state or country) <u>Dallas, Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Arthur Raymond Bogan</u>		13b. MOTHER'S MAIDEN NAME <u>Helen Wilcox</u>		14. NAME OF HUSBAND OR WIFE <u>Margaret Calhoun Bogan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>No None</u>		16. SOCIAL SECURITY NO. <u>492-05-7584</u>	17. INFORMANT Address <u>Margaret Calhoun Bogan 7625 Shirley Drive</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute hemorrhage pancreatitis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					<u>587.0</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>June 1957</u> , to <u>May 3 1958</u> and last saw her alive on <u>May 2, 1958</u> Death occurred at <u>2 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Sidney Jick</u> (Degree or title) <u>0 M.D.</u>			22b. ADDRESS <u>457 N. Kingshighway</u>		22c. DATE SIGNED <u>5/3/1958</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>5/5/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>C. R. Lupton & Sons 7233 Delmar Blvd.</u>			25. DATE RECD. BY LOCAL REG. <u>MAY 5 1958</u>	26. REGISTRAR'S SIGNATURE <u>Pearl Smith M.D.</u>	

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 *Arnold W. Schaeene*

Licensed Embalmer No. *3864*
P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.