

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-047182

STATE FILE NUMBER

RECORDED JAN 26 1959 Station District No. 156 Primary Registration District No. 2001 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY JASPER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JASPER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JOPLIN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN JOPLIN 0495
c. FULL NAME OF (If in hospital, give location) HOSPITAL OR INSTITUTION JOPLIN GENERAL HOSP.		Length of stay in 1b 17 yrs	d. STREET ADDRESS (If outside, give location) 727 KENTUCKY AVE.
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last JAMES FLORION H. OGLESBY			4. DATE OF DEATH Month Day Year DECEMBER 28, 1958	
--	--	--	---	--

5. SEX M 0	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 9, 1885	9. AGE (In years last birthday) 73	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) MESSENGER	10b. KIND OF BUSINESS OR INDUSTRY RAILWAY EXPRESS AGCY	11. BIRTHPLACE (City and state or country) CLARENCE, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	---	---	--

13a. FATHER'S NAME SAMUEL OGLESBY	13b. MOTHER'S MAIDEN NAME CAPITOLA CUNNINGHAM	14. NAME OF HUSBAND OR WIFE Agnes Oglesby
--------------------------------------	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and dates of service) No	16. SOCIAL SECURITY NO. UNK	17. INFORMANT Address MRS. NELLIE E. OGLESBY, 727 KENTUCKY
---	--------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Circulatory Failure		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Coronary Thrombosis with Myocardial Infarction		30 min.
	DUE TO (c) Arteriosclerosis		Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> None <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 8-10-54 to 12-28-58 and last saw him alive on 9-18-58 Death occurred at 10:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE <i>J. E. Stephens</i> (Degree or title)	22b. ADDRESS D.O. 2 211 W. 20th St., Joplin, Mo.	22c. DATE SIGNED 12-30-58
---	---	------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12-31-58	23c. NAME OF CEMETERY OR CREMATORY GIBSON CEMETERY, NEAR NEOSHO, MISSOURI	23d. LOCATION (City, town, or county) (State) NEOSHO, MISSOURI
---	-----------------------	--	---

24. FUNERAL DIRECTOR STEVE PARKER MORTUARY, JOPLIN, MO.	25. DATE RECD. BY LOCAL REG. 1-12-1959	26. REGISTRAR'S SIGNATURE <i>Dove Merriam</i>
--	---	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

6961 9 831
FEB 6 1959

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 *F. M. Jones*

Licensed Embalmer No. *2319*
P. O. Address *Joplin, 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.