

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001589

STATE FILE NUMBER

FILED FEB 3 1959 Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 48

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY OR TOWN Independence		c. CITY OR TOWN Independence	
c. FULL NAME OF HOSPITAL OR INSTITUTION 131 So. Fuller		d. STREET ADDRESS 131 So. Fuller	
3. NAME OF DECEASED (Type or print) Arthur W. Bogue		4. DATE OF DEATH Month Jan. Day 23 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Benson Manuf. Co.	11. BIRTHPLACE (City and state or country) Nebuda Iowa
13a. FATHER'S NAME Joseph Bogue		13b. MOTHER'S MAIDEN NAME Janet H. Smith	14. NAME OF HUSBAND OR WIFE Grace Bogue
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. 493-12-0110	17. INFORMANT Address Mrs. Grace Bogue 131 So. Fuller Indep. Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot, chest			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Self Inflicted		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. 1:23 59 p.m. _____	20d. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) Residence		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION COUNTY STATE Independence Jackson Mo		
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Ruth A. Quinn Coroner		22b. ADDRESS 1034 Pratts Blv	
22c. DATE SIGNED 1-24-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removed	23b. DATE Jan. 26, 1959	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City, town, or county) (State) Lamoni Iowa
24. FUNERAL DIRECTOR ADDRESS Geo. C. Carson & Sons Independence, Mo.		25. DATE RECD. BY LOCAL REG. 1-26-59	26. REGISTRAR'S SIGNATURE Ruth A. Quinn

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

FEB 3 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 *J. H. Gibson*

Licensed Embalmer No. *4871*

P. O. Address *Indep. 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.