

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS OCT 23 1959**

**2 9451** **59-037925**  
 REGISTRATION DISTRICT NO. \_\_\_\_\_ PRIMARY REGISTRATION DISTRICT NO. \_\_\_\_\_ REGISTRAR'S NO. \_\_\_\_\_ STATE FILE NUMBER

UNRECORDED

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis Mo.</b> Length of stay in 1b _____ c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>447I Olive St.</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____ c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>447I Olive St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Cora</b> Middle <b>M.</b> Last <b>Ogles</b>			<b>4. DATE OF DEATH</b> Month <b>Oct</b> Day <b>13</b> Year <b>1959</b>				
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. Married</b> <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Apr. 12 1893</b>	<b>9. AGE (last birthday)</b> <b>66</b>	<b>IF UNDER 1 YEAR</b> Months <b>6</b> Days _____ Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk Retired</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Dept. Store</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>De Soto Ill.</b>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S. A.</b>		<b>13a. FATHER'S NAME</b> <b>Corum Ogles</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Margaret Murray</b>			
<b>14. NAME OF HUSBAND OR WIFE</b> _____		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>492 12 1365</b>			
<b>17. INFORMANT</b> <b>Eather Dagon</b>		<b>Address</b> <b>447I Olive St.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nephritis.</b> DUE TO (b) _____ DUE TO (c) <b>593x</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>Anemia</b>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____				
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____ COUNTY _____ STATE _____					
<b>21. I attended the deceased from</b> <b>March 30/59</b> to <b>Oct 17/59</b> and last saw her alive on <b>Oct 1/59</b> Death occurred at <b>447I Olive</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>J. M. Black M.D.</b>			<b>22b. ADDRESS</b> <b>7057N. Kingshighway</b>		<b>22c. DATE SIGNED</b> <b>10/14/59</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>Oct. 17 1959</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Valhalla Cemetery</b>			
<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis Co. Mo.</b>		<b>24. FUNERAL DIRECTOR</b> <b>Collier Funeral Home</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>OCT 15 '59</b>			
<b>24. ADDRESS</b> <b>10123 St. C</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Earl Smith M.D.</b> E.P.					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Elton H. Remelund

Licensed Embalmer No. 4283

P. O. Address St. Louis

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.