

1. PLACE OF DEATH
 a. COUNTY
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **ST. LOUIS, MISSOURI** Length of stay in 1b **13 DAYS**
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **VAH, 915 NORTH GRAND AVE.** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **MISSOURI** b. COUNTY **Jefferson**
 c. CITY OR TOWN **HILLSBORO** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **ROUTE 2** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
CLYDE F. OGLESBY **4/6/61**

5. SEX **MALE** 6. COLOR OR RACE **WHITE** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **4/9/17** 9. AGE (last birthday) **43**
 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **PLUMBER** 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) **MARKED TREE, ARKANSAS** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **FRED OGLESBY** 13b. MOTHER'S MAIDEN NAME **MARY HERAL** 14. NAME OF HUSBAND OR WIFE **EHRLINE OGLESBY**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **YES WW-I** 16. SOCIAL SECURITY NO. 17. INFORMANT **EHRLINE OGLESBY (WIDOW) SEE #2** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **PNEUMONIA** INTERVAL BETWEEN ONSET AND DEATH
 DUE TO (b) **ATELECTASIS** **163x**
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) **CARCINOMA OF RIGHT LUNG, SUSPECTED**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **BRAIN TUMOR, SUSPECTED** PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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
 20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. attended the deceased from **3/24/61** to **4/6/61** and last saw him ^{xxx} alive on **4/6/61**
 Death occurred at **6:00 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Doctor or title) **Donald O. Sullivan M.D.** 22b. ADDRESS **VAH, ST. LOUIS, MO.** 22c. DATE SIGNED **4/6/61**

23a. BURIAL-CREMATATION, REMOVAL (Specify) **REMOVAL** 23b. DATE **APR. 8 1961** 23c. NAME OF CEMETERY OR CREMATORY **MASONIC CEMETERY** 23d. LOCATION (City, town, or county) (State) **BLACKWELL, MO.**

24. FUNERAL DIRECTOR **DIETRICH F. HOME DESOTO Mo.** ADDRESS 25. DATE RECD. BY LOCAL REG. **APR 8 1961** 26. REGISTRAR'S SIGNATURE **Lead Smith, M.D.**

DATE AMENDED
 INSTEAD OF
 ITEM NO.
 SHOULD READ
 BY AFFIDAVIT OF

DOCUMENT
 MEDICAL CERTIFICATION

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 Donnell B. Dietrich

Licensed Embalmer No. 4404

P. O. Address 125th St. N.W.

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.