

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 37 Primary Registration District No. 4214 Registrar's No. 0010396 STATE FILE NUMBER

MARRIED 16 64

VS 300
Rev. 4/59

1 0420
2 0420
3
4 0
5 2
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7 1
8 2
9 200
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11
12 900
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Henry</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Henry</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Deepwater</u>		Length of stay in 1b <u>3 yrs.</u>	c. CITY OR TOWN <u>Deepwater</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RFD. #1,</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RFD. # 1,</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Madison</u> Last <u>Ogan</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>12,</u> Year <u>1964</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/6/1863</u>	9. AGE (last birthday) <u>100</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau Co., Ill</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Simon Peter Ogan</u>		13b. MOTHER'S MAIDEN NAME <u>Emily Sturtevant</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Ray Graham, RFD. # 1</u> Address <u>Deepwater, Mo.</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>Atheros - aortic heart disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
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) <u>None</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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>12/11/45</u> to <u>3/12/64</u> and last saw him alive on <u>2/19/64</u> Death occurred at <u>7:00 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>S. B. Hughes M.D.</u>			22b. ADDRESS <u>Clinton, Mo.</u>		22c. DATE SIGNED <u>3/14/64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>March 15, 1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Montrose Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Montrose, Mo.</u>		
24. FUNERAL DIRECTOR <u>Vansant Funeral Home, Clinton, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>MAR. 14, 1964</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

08-17-64

08-17-64

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 A.A. Vausant

Licensed Embalmer No. 3779

P. O. Address Clinton, 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.

Permit Obtained 3-14-64

M.B.