

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County St. Charles
Township Unives
or
Village _____
or
City _____ (NO. _____)

Registration District No. 758 File No. 7723
Primary Registration District No. 5999 Registered No. 3

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Albert - L Ogelsby

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE Negro ~~SINGLE~~ ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ Widowed
(Write the word)

DATE OF DEATH Jan 29, 1911
(Month) (Day) (Year)

DATE OF BIRTH April 10, 1860
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 20, 1911, to Jan 29, 1911, that I last saw him alive on Jan 28, 1911,

AGE 50 yrs. 9 mos. 19 ds. If LESS than 1 day, ___ hrs. or ___ min.?

and that death occurred, on the date stated above, at 5 A. m.

OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 1 - 000

The CAUSE OF DEATH* was as follows:
Pneumonia (Lobar)
108

BIRTHPLACE (City or town, State or foreign country) (Unives Va)

PARENTS NAME OF FATHER Benj Ogelsby
BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia
MAIDEN NAME OF MOTHER Patey Byrd
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Blum Mallas M. D.
Feb 3, 1911 (Address) Forrestell

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Walter Ogelsby
(ADDRESS) Forrestell

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____

Filed Feb 3, 1911 J. A. Reid REGISTRAR

UNDERTAKER Nieberg Mfg Co ADDRESS Wright City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sar-*

coma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

PLACE OF DEATH

County St. Charles
Township Cuiver
or
Village
or
City

REGISTRARS SHALL NOT RE-
CEIVE A FEE FOR CERTIFICATES
UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.
Registration District No. 158

Primary Registration District No. 5999

File No. 7723
Registered No. 3

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

Albert L. Ogelsby

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE negro SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)
DATE OF BIRTH April 10, 1860
(Month) (Day) (Year)
AGE 50 yrs. 9 mos. 19 ds. if LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

DATE OF DEATH Jan 29, 1911
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Jan 20, 1911, to Jan 29, 1911, that I last saw him alive on Jan 28, 1911, and that death occurred, on the date stated above, at 5th m. The CAUSE OF DEATH* was as follows:
Pneumonia (Lobar)

BIRTHPLACE

(City or town, State or foreign country) Cuiver, Mo.

(Duration) ____ yrs. ____ mos. 9 ds.

PARENTS
NAME OF FATHER Benz Ogelsby
BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia
MAIDEN NAME OF MOTHER Caley's Durd
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

Contributory (SECONDARY) A. C. M. Miller
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) A. C. M. Miller M. D.
St. 3, 1911 (Address) Forestell

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Ogelsby
(ADDRESS) Forestell

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted if not at place of death?
Former or usual residence

Filed 2-5-1911 James A. Reid REGISTRAR

PLACE OF BURIAL OR REMOVAL Forestell, Mo. DATE OF BURIAL 1-30-1911
UNDERTAKER Hubburg Hfg. Co. Knight City ADDRESS

FEB

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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