DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21405

Registration District No. 125 Primary Registration District No. 3009 Registrar's No. 217

1. PLACE OF DEATH:

(a) County Cape Girardeau, 1

(b) City or town Cape Girardeau, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Southeast Missouri Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Eight Hours (Specify whether years, months or days)

In this community 15 years

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME James Wilmer Ogle,

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Zula A. Ogle

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased April (Month) 4 (Day) 1874 (Year)

8. AGE: Years 66 Months 2 Days 17 If less than one day hr. min.

9. Birthplace Pike Co, Rockport, Ill., 1
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Farming 1

FATHER
12. Name Ogle
13. Birthplace Ohio 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Susan Barry
15. Birthplace Cincinnati, Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Zula A. Ogle

(b) Address R #3 Sikeston, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/40 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetary

18. (a) Signature of funeral director G. A. Dempster

(b) Address Sikeston Mo

19. (a) 6-21-40 (Date received local registrar) (b) J. M. Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21 year hour 9 minute 45 9 M.

21. I hereby certify that I attended the deceased from June 21, 1940, to June 21, 1940; that I last saw him alive on June 21, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Sigmoid c perforation into General Abdominal Cavity

Due to

Due to

Other conditions Hod gastric resection
(Include pregnancy within 3 months of death)
Ca. Pylorus 6 mo ago. Barnes Hosp.

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature D. B. Elrod (M. D. or other)

Address Cape Girardeau Mo Date signed 6/24/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

Rev. 3-17-39 I X19511

46

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed G A Dempster

Licensed Embalmer No. 2021

P. O. Address Sikeston 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 this body is not embalmed, above space should be left blank.

S. No. 2B
4—2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21405-

Registration District No. 125- Primary Registration District No. 3009 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Cape G.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County New Madrid
(c) City or town Moorehouse
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME James Wilmer Ogle
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days 17 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from 19..., to 19...; that I last saw h... alive on 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Sigmoid. — Duration
Due to Perforation into the General abdominal Cavity
Due to Primary Ca Sigmoid
Other conditions (Include pregnancy within 3 months of death) Had colic resection Ca Ryloma 6 mo ago
Major findings Of operations
Remarks: Pt had two primary Carcinomas — Stomach & Sigmoid Rectal Junction.

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) 4-6
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury
23. Signature D. B. Elrod (M. D. or other)
Address Cape Girardeau Date signed

SUPPLEMENTARY

B
40
2659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21403

Registration District No. 125 Primary Registration District No. 3009 Registrar's No.

1. PLACE OF DEATH:
(a) County Cape Gir
(b) City or town Cape Gir
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County New Madrid
(c) City or town Morehouse, Mo
(If outside city or town limits write "RURAL")
(d) Street No. — (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME James Wilmer Ogle
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
66	2	17	hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) Meiton Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work (Specify type of place) (e) Means of injury
23. Signature D. B. Elrod (M. D. or other)
Address Cape Gi. Date signed

SUPPLEMENTARY