

Registration District No. 791 Primary Registration District No. 1003

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

NOV 16 1940

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution:
4115 Ashland Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20
In this community 20
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Philomene Bogardus

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Charles Bogardus 6. (c) Age of husband or wife if alive September 15 1860 years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 80 Months 1 Days 4 If less than one day hr. min.

9. Birthplace Perryville Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name Joseph Pannier

13. Birthplace Unknown France
(State or foreign country)

14. Maiden name Esterie Pravalle

15. Birthplace Unknown France
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Frank Howard
(b) Address 4115 Ashland Ave.

17. (a) Burial (b) Date thereof 10-24-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery Cullinane Bros.

18. (a) Signature of funeral director _____
(b) Address 1710 N. Grand Blvd.

19. OCT 23 1940 (Date received local registrar) (b) J. P. Deidich (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 4115 Ashland Ave. (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 19
year 1940 hour 11 minute 50 P.M.

21. I hereby certify that I attended the deceased from Oct 17
1940 to Oct 19 1940
that I last saw her alive on Oct 19 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoria Duration 3 day

Due to not known

Due to _____
Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations none Of autopsy none

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) no
(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 Dr. N. F. Miller (M. D. or _____)
Address 8410 N. Broadway Date signed 10-27-40

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 *Fred Frick*

Licensed Embalmer No. 3186

P. O. Address St. Louis, 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.