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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 11 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6284

Registration District No. 85 | Primary Registration District No. 1001 | Registrar's No. 159

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

11
1
7

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2117 S.4th. / (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 47 Years 1Mo.10Days.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan 11

(c) City or town St. Joseph / (If outside city or town limits, write "RURAL")

(d) Street No. 2117 S.4th. 7 (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME RHODA BELLE OGLE

3. (b) If veteran, name war none

3. (c) Social Security No. nome

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife Gene Ogle

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Dec. (Month) 25th. (Day) 1893 (Year)

8. AGE: Years 47 | Months 1 | Days 10 | If less than one day ___ hr. ___ min.

9. Birthplace St. Joseph (City, town, or county) 0 Mo. (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

FATHER
12. Name William Perman
13. Birthplace DesMoines (City, town, or county) / Iowa (State or foreign country)

MOTHER
14. Maiden name May Hilton
15. Birthplace Hamburg (City, town, or county) / Iowa (State or foreign country)

16. (a) Informant Ben Dakon

(b) Address 1020 N.9th. St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 -8 -41 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director FLEEMAN & SON, INC.

(b) Address St. Joseph, Mo.

19. (a) Feb 8-1941 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 5th. year 1941 hour 8 minute 00 P.M.

21. I hereby certify that I attended the deceased from did not see patient alone, 19__; that I last saw her alive on Dead on arrival 8:20 P.M. and that death occurred on the date and hour stated above.

Immediate cause of death Apparently died of acute heart failure

Due to Superimposed on a respiratory infection of a weeks duration

Due to Nature of heart disease not determined

Other conditions no evidence of violence (Include pregnancy within 3 months of death)

Major findings:
Of operations –
Of autopsy –

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

200 W

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)

8 5

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) [signature]

Address Kirkpatrick Bldg. Date signed 1-7-41

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

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.....

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

working under my personal supervision.

Signed Geo E Daniel

Licensed Embalmer No. 3300

P. O. Address St Joseph 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, fact should be so stated above.