

No. 2
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5-17-39
1 X4707

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 30 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14728

State File No. _____

Registration District No. 285

Primary Registration District No. 6047

Registrar's No. _____

1. PLACE OF DEATH
(a) County St. Charles
(b) City or town Paris
(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 Months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo
(b) City or town Paris
(c) Name of hospital or institution: Rural
(If rural, give location)
(d) Street No. _____
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Walter Oglesby
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 4 day 16
year 47 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from 11-15
1946 to 4-16 1947
that I last saw him alive on 4-16 1947
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Negro
6. (a) Single, widowed, married, divorced Single
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 12 1891
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage
Due to Arteriosclerosis
Other conditions (include pregnancy within 3 months of death) _____
Major findings:
Of operations _____
Of autopsy _____

8. AGE: Years 75 Months 9 Days 4
If less than one day _____ hr. _____ min.
9. Birthplace Paris (City, town, or county) Mo (State or foreign country)

10. Usual occupation farmer
11. Industry or business _____
12. Name Bonnie Oglesby
13. Birthplace Virginia (City, town, or county) (State or foreign country)

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 _____

14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)
16. (a) Informant Mary L. Buckner
(b) Address Paris Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Paris Mo (Month) (Day) (Year)
(c) Place: burial or cremation Paris Mo
18. (a) Signature of funeral director Wentworth
(b) Address Paris Mo
19. (a) 4/23/47 (Data received local registrar) (b) Miss J. Lewis (Registrar's signature)

21. Signature Raymond H. Hays (M.D. or other) 83A
Address Paris City, Mo. Date signed 4-18-47

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

0
0
0

Duration

1 Day

1 yr +

PHYSICIAN

Underline the cause to which death should be charged statistically.

Date Filed 4-29-47

District File Number

District Health Officer No. 9,

RECEIVED

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

William A. Folger

, Registered Apprentice No. 499

working under my personal supervision.

Signed

W. A. Folger

Licensed Embalmer No. 2711

P. O. Address Wentzville, 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.