

No. 300  
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5-17-39  
8906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED APR 30 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 14517  
Registrar's No. 3677

Registration District No. ....

Primary Registration District No. ....

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

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 days  
In this community.....  
years, months or days)

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

4. Sex Male 5. Color or race col  
6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife Addie  
6. (c) Age of husband or wife if alive 38 years  
7. Birth date of deceased June 16 (Month) 1902 (Day) (Year)

8. AGE: Years 45 Months 19 Days 28  
If less than one day hr. min.

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

10. Usual occupation Funeral Director

11. Industry or business.....

12. Name Charley Oglesby

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

14. Maiden name Cora Edwards

15. Birthplace Wright City, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Addie Oglesby

(b) Address 4059 Aldine

17. (a) Burial (b) Date thereof 4-18-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Foristell, Mo.

18. (a) Signature of funeral director E. Wade Granberry

(b) Address 4202 Finney

19. (a) APR 18 1948 (b) J. F. Bredeck  
(Date received local registrar) (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. 4059 Aldine St  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14  
year 1948 hour 7 minute P M.

21. I hereby certify that I attended the deceased from  
April 5, 1948, to April 14, 1948  
that I last saw him alive on April 14, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Lobar Pneumonia  
Bilateral Hydrothorax

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy No

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) (Means of injury)

23. Signature Oscar J. Daniels  
Address 2601 N Whittier Date signed 4/15/48

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

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**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..... *Melvin E. Green*  
Licensed Embalmer No. .... *4428*  
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, fact should be so stated above.**

Registration District No. *318*

Primary Registration District No. *1003*

Registrar's No. *3677*

1. PLACE OF DEATH:

(a) County.....  
 (b) City or town.....  
 (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  
 In this community.....  
 years, months or days)

3. (a) PRINT FULL NAME

*Charles Oglesby*

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex *m* 5. Color or race *B* 6. (a) Single, widowed, married, divorced *married*

6. (b) Name of husband or wife *addie* 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased *June 16*  
 (Month) (Day) (Year)

8. AGE: Years *45* Months *9* Days *2* If less than one day hr. min.

9. Birthplace *mo*  
 (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....  
 (City, town, or county) (State or foreign country)

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b) *J. F. Brudeck*  
 (Date received local registrar) (Registrar's signature)

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) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *May* Day *14*  
 year *1948* hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....

that I last saw him..... alive on....., 19.....

and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations.....

Of autopsy.....

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..... (M. D. or other)

Address..... Date signed.....

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

**SUPPLEMENTARY**

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MAY 15 1948

S-14517

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