

FILED AUG 29 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26433

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>72</u>		PRIMARY REG. DIST. NO. <u>3013</u>		Registrar's No. <u>91</u>	
1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>North Kansas City</u>		c. LENGTH OF STAY (In this place) <u>10 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>North Kansas City</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>1037 East 24th</u>				d. STREET ADDRESS (If rural, give location) <u>1037 East 24th</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Geneva</u>			b. (Middle) _____		c. (Last) <u>Ogilvie</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 15 '49</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married 1</u>		8. DATE OF BIRTH <u>Nov. 24, 1888</u>		9. AGE (In years last birthday) <u>60</u>	IF UNDER 1 YEAR Months   Days   Hours   Min. <u>9   24   16   -</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Longview Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Charles B. Cunningham</u>			13b. MOTHER'S MAIDEN NAME <u>Geneva Whitehead</u>		14. NAME OF HUSBAND OR WIFE <u>A.W. Ogilvie</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT'S SIGNATURE OR NAME <u>A.W. Ogilvie</u>		ADDRESS <u>1037 E. 24th</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Broncho-pneumonia - Terminal</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Lorcinoma gall bladder w/lt</u> DUE TO (c) <u>extensive metastasis to</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes mellitus. Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH           <u>155 X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1</u> , 19 <u>49</u> , to <u>Aug 15</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Aug 15</u> , 19 <u>49</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Specify or title) <u>John S. Kitchener</u>				23b. ADDRESS <u>1037 E. 24th</u>		23c. DATE SIGNED <u>Aug 17, 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>017 Aug 49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>N.W. Washington</u>		24d. LOCATION (City, town, or county) (State) <u>W.C. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Aug 17 - 49</u>		REGISTRAR'S SIGNATURE <u>Beulah Kitchener</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Kitchener</u>		ADDRESS <u>N.K.C.</u>	

(Licensed Embalmer's Signature on Reverse Side)

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

No. 300

10.48

RECEIVED

AUG 22

District Health Officer No. 8,

District File Number.....

Date Filed 8-27-49

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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Harold L. Bosson

Licensed Embalmer No. ....

P. O. Address.....

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.