

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13054**
1702

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
c. LENGTH OF STAY (in this place) 60 yrs		d. STREET ADDRESS (If rural, give location) 3441 CAMPBELL	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3441 CAMPBELL			

3. NAME OF DECEASED (Type or Print) MINNIE			4. DATE OF DEATH 4 - 11 - 52		
a. (First)	b. (Middle) M	c. (Last) OGDEN	Month	Day	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH AUG. 31, 1869	9. AGE (In years last birthday) 82	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) SIOUX CITY, IOWA		

13a. FATHER'S NAME A. HARVEY MATEER		13b. MOTHER'S MAIDEN NAME SARA HAZELTON MATEER		14. NAME OF HUSBAND OR WIFE CLARK WM. OGDEN	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NO	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Mr. WHITNEY OGDEN 3441 CAMPBELL			
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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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		DUE TO (b) Unknown			Unknown
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) Unknown			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Obesity, Arteriosclerosis			4201

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
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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)	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 **Sept 11, 1950**, to **April 11, 1952**, (last saw the deceased) **by telephone** and that death occurred at **10:30 pm.**, from the causes and on the date stated above.

23a. SIGNATURE Harold A. Pallett (Degree or title) MD		23b. ADDRESS 1132 Paul Blvd. KC, Mo.		23c. DATE SIGNED 4/12/52	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-15-52	24c. NAME OF CEMETERY OR CREMATORY MT. WASHINGTON	24d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.		
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DATE REC'D BY LOCAL REG. 4-14-52	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS STINE & McCLURE KANSAS CITY, MO.			
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(Licensed Embalmer's Statement on Reverse Side)

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

*the name of
B. ...*

2-1486

*10116
15/15/15
15/15/15*

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 *Gerald A. Burger*

Licensed Embalmer No. *4763*

P. O. Address *K. C. 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.