

FILED APR 22 1957

318

1003

STATE FILE NUMBER

3255

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION WARWICK HOTEL		d. STREET ADDRESS 1428 Locust St. WARWICK HOTEL	
3. NAME OF DECEASED (Type or print) MORTON H BOGIE		4. DATE OF DEATH APRIL 1st 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 4, 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN - B-1 BOTTLING COMPANY		10b. KIND OF BUSINESS OR INDUSTRY LING COMPANY	11. BIRTHPLACE (City and state or country) RICHMOND, MISSOURI
13. FATHER'S NAME RECTOR S. BOGIE		14. MOTHER'S MAIDEN NAME BETTY DuVAL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give dates of service) NONE		16. SOCIAL SECURITY NO. 4301-88-475	17. INFORMANT MARJORIE B. LEWIS 1231 FERNDALE
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocarditis</i> DUE TO (b) <i>Arterio-Sclerosis</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) 422.1			INTERVAL BETWEEN ONSET AND DEATH 2 years 3 years
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 5-2-1953, to 4-1-57 and last saw <sup>her</sup> him alive on MARCH-18-1957 Death occurred at 4-1-1957 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Langston R. Williams M.D.</i>		22b. ADDRESS 812 Olive	22c. DATE SIGNED 4-3-57
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4-5-1957	23c. NAME OF CEMETERY OR CREMATORY OAK GORVE CREMATORY	23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO.
24. FUNERAL DIRECTOR C.R. LUPTON AND SONS 7233 Delmar		25. DATE RECD. BY LOCAL REG. Blv*d. APR 3 '57	26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>

(Licensed Embalmer's Statement on Reverse Side)

S. 300  
v. 1-56

All symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

securing the medical certificate in the same manner as a death certificate.

mga

**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.....  
Signature of Student Embalmer

Signed *Clarence H. Murray*

Licensed Embalmer No. *401*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.