

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-031179

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 002 Primary Registration District No. 5019 Registrar's No. 47

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 19 1963

VS 300	DATE AMENDED
Rev. 4/59	
1 0020	
2 20020	
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4 0	
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12 86-0	
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Andrew</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rochester Township</u>		c. CITY OR TOWN <u>Whitesville</u>	
Length of stay in 1b <u>3 months</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Shady Lawn</u>		d. STREET ADDRESS (If outside, give location) <u>Whitesville</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Ogle</u>			4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1963</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-78</u>
9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	11. BIRTHPLACE (City and state or country) <u>Whitesville, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		13a. FATHER'S NAME <u>Joseph Ogle</u>	
13b. MOTHER'S MAIDEN NAME <u>Catherine Agee</u>		14. NAME OF HUSBAND OR WIFE <u>Eliza Ogle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Floyd Townsend, Savannah, Mo.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>
DUE TO (b) <u>Arterio-sclerotic heart disease</u>			<u>2 years</u>
DUE TO (c) <u> </u>			<u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input 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.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. CITY, TOWN, OR LOCATION <u>Whitesville</u>		COUNTY <u>Andrew</u> STATE <u>Missouri</u>	
21. I attended the deceased from <u>7-30-56</u> to <u>8-14-63</u> and last saw ^{X₂X} him alive on <u>7-13-63</u> Death occurred at <u>9:15 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Harold Baber M.D.</u> (Degree or title)		22b. ADDRESS <u>Savannah, Missouri</u>	
22c. DATE SIGNED <u>8-16-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>8-16-63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Whitesville Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Whitesville, Mo.</u>	
24. FUNERAL DIRECTOR <u>BREIT & HAWKINS</u> ADDRESS <u>SAVANNAH</u>		25. DATE RECD. BY LOCAL REG. <u>8-17-1963</u>	
26. REGISTRAR'S SIGNATURE <u>Deborah Williams</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

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 James B. Hawkins

Licensed Embalmer No. 4536

P. O. Address Savannah

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.