

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-033976

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8749** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1
2 *220*
3
4 *0*
5 *1*
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7 *1*
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12 *60-1*
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 12 days		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Faith Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2309 Angelica Ave.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leland E. Ogden						4. DATE OF DEATH Month: 8 Day: 29 Year: 63					
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7/14/90		9. AGE (last birthday) 73		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer - Ret.				10b. KIND OF BUSINESS OR INDUSTRY Plaster		11. BIRTHPLACE (City and state or country) Wapello, Iowa		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Frank Ogden				13b. MOTHER'S MAIDEN NAME Janet Thompson				14. NAME OF HUSBAND OR WIFE Verena Ogden			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Verena Ogden, 2309 Angelica					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) auricular flutter - pulmonary										INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause - last. DUE TO (b) cardiac decompensation										- twice	
DUE TO (c) chronic pulmonary insufficiency										?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5271										PART II. 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 checked="" type="checkbox"/> NO <input 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.)							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE			
21. I attended the deceased from 4-10-59 to _____ and last saw him alive on 8-29-63 Death occurred at 6:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>[Signature]</i> (Degree or title)						22b. ADDRESS ST LOUIS MO 3400 N. KENTZLEY		22c. DATE SIGNED 8/29/63 (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)					
burial		8/31/63		New Picker Cemetery		St. Louis		Mo.			
24. FUNERAL DIRECTOR Drehmann-Harral				ADDRESS 1905 Union		25. DATE REC'D. BY LOCAL REG. AUG 29 1963		26. REGISTRAR'S SIGNATURE <i>[Signature]</i> M.D.			

Dr. Jos. E. Cacioppo
3400 N. Kingshighway

Hrs. 10:30 - 12 Noon
Thurs.

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

Warren A. Carver

Licensed Embalmer No.

3534

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

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