

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

FILED JUL 8 1948

State File No.

Registration District No. 1798

Primary Registration District No. 3011

Registrar's No. 94

1. PLACE OF DEATH:

(a) County CLAY

(b) City or town Excelsior Springs
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4201 Kansas City Ave.
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution no
(Specify whether)

In this community 30 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Clay ²⁴

(c) City or town Excelsior Springs
(If outside city or town limits, write "RURAL")

(d) Street No. 420 Kansas City Ave.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME ORA FRANCIS BOGART

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4
year 1948 hour 5 minute 30 P M.

21. I hereby certify that I attended the deceased from May 1
1948 to June 4 1948
that I last saw her alive on June 4 1948
and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race white

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Harve Bogart

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec 7 1873
(Month) (Day) (Year)

Immediate cause of death Coronary Arteriosclerosis ^{Duration} 12 or 15 hrs

8. AGE: Years Months Days If less than one day

68 5 7 hr. min.

Due to General arteriosclerosis

9. Birthplace Callaway Co. MO
(City, town, or county) (State or foreign country)

Due to athmatic

Other conditions athmatic
(Include pregnancy within 3 months of death)

10. Usual occupation at home

11. Industry or business

MOTHER FATHER { 12. Name John Johnson

{ 13. Birthplace unknow unknow
(City, town, or county) (State or foreign country)

{ 14. Maiden name Jeynne Bell

{ 15. Birthplace unknow MO
(City, town, or county) (State or foreign country)

Major findings: none

Of operations none

Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant R. J. O'Dell

(b) Address Road 2, Excelsior Springs

17. (a) Burial (b) Date thereof June 6 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill, E. Sp.

18. (a) Signature of funeral director Herbert Pope

(b) Address Excelsior Springs

19. (a) 6-15-48 Mrs. Sade Pedmont
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no (Specify type of place) (e) Means of injury

23. Signature E. D. Craven (M. D. or other)

Address Excelsior Springs Date signed 6-5-48

1166

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 7-7-42

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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed Chas. Virgil Hope

Licensed Embalmer No. 3950

P. O. Address Excelsior Springs

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.

Registration District No. 198

Primary Registration District No. 3011

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Ora H. Bogart

3. (b) If veteran, name war _____ 3. Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 7 1897
(Month) (Day) (Year)

8. AGE: Years 68 Months 5 Days 10 min. _____
If less than one day

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry of business _____

12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Jan day _____
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____
to _____, 19____
that I last saw him _____ live on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Arteriosclerosis -
Due to chronic nephritis
and atherosclerosis
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature J. D. Weaver (M. D. or other) _____
Address Excelsior Springs, Mo Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

