

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

399

28691

1. PLACE OF DEATH

County Jackson
 Township Bar
 City Ransom City (No. Research Hospital)

Registration District No. 8003
 Primary Registration District No. 8003

File No. 8327
 Registered No. 8327
 St. _____ Ward _____

2. FULL NAME

Angusta Middleton Ogden

(a) Residence. No. 1440 - Admiral St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 3 1/2 How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) yes - ✓

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Caroline Brown Ogden

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July-2-1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 2 11

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Chemist
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) mo.

10. NAME OF FATHER Martin Ogden

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) mo.

12. MAIDEN NAME OF MOTHER Marta Jane

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) mo.

14. INFORMANT Caroline Brown Ogden (Address) 1440 Admiral Blvd

15. Sept 14, 1926 J. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept-13 1926

17. I HEREBY CERTIFY, that patient deceased from Sept 6, 1926, to Sept 13, 1926, that I last saw her alive on Sept 13, 1926, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Abscess
1105
1111
 _____ (duration) yrs. mos. 4 da.
 CONTRIBUTORY Pleurisy with effusion
 (SECONDARY) acute infection
 _____ (duration) yrs. mos. 9 da.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH: His Residence 1440 Admiral Blvd

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? X-ray
 (Signed) Ralph W. Bachman, M. D.
1130, 1926 (Address) 816 Lathrop Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Clarksburg mo. DATE OF BURIAL Sept-15-1926

20. UNDERTAKER Mrs. C. A. Foster ADDRESS A.C. mo.

PARENTS

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Intantion," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

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ALL INFORMATION OBTAINED
HEREIN IS UNCLASSIFIED
EXCEPT WHERE SHOWN
OTHERWISE. THIS DOCUMENT
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.
Township..... Primary Registration District No. 1002 Registered No. 3627
City Kansas City (No.) St. Ward

2. FULL NAME Augusta Middleton Ogden

(a) Residence. No. St. Ward

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of (foreign birth?) yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) x

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 9/14/26 M.M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 13 - 1926

17. I HEREBY CERTIFY That I attended deceased from

19..... to, 19..... that I last saw him alive on, 19..... and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary abscess - not bacterial not tubercular
..... (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Pleurisy with effusion - acute infectious
..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH?

DATE OF

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Robert M. Hapgood, M.D.

, 19 (Address) 816 Kalamazoo Kelly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSED, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

SUPPLEMENTARY

S-28-71