N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH

County: Cooper

Township: _____ or Village: Otterville or City: _____ (NO. _____ St.; _____ Ward)

Registration District No. 221 — Primary Registration District No. 590273

File No. 38781 — Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Abe Lincoln Hogan

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Black	Single

DATE OF BIRTH: June 1st, 1916 (Month) (Day) (Year)

AGE: 2 yrs. 10 mos. 3 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: 11A

(b) General nature of industry, business, or establishment in which employed (or employer): 108

BIRTHPLACE (City or town, State or foreign country): Cooper Co Mo

PARENTS

NAME OF FATHER: Guss Hogan

BIRTHPLACE OF FATHER (City or town, State or foreign country): Cooper Co Mo

MAIDEN NAME OF MOTHER: Grace Finley

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Cooper Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Guss Hogan

(ADDRESS): Otterville Mo

Filed Dec 4, 1918. F. J. Varney, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: November 10, 1918 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 4, 1918, to Nov 9, 1918, that I last saw him alive on Nov 9, 1918, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

10 Lobar Pneumonia

(Duration) ____ yrs. ____ mos. 5 ds.

Contributory (Secondary): Influenza

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. Benton Kleinsch, M. D.

Nov 10, 1918 (Address) Otterville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Otterville Mo

DATE OF BURIAL: Nov 11, 1918

UNDERTAKER: H. Spiess

ADDRESS: Otterville Mo

PLACE OF DEATH

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

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

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

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

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to ....., 191...., that I last saw h..... alive on ....., 191...., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191....
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.