

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

Do not use this space.

38148

1. PLACE OF DEATH

County St. Louis
Township Central
City Richmond Heights (No. St. Marys Hospital)

Registration District No. 1170
Primary Registration District No. 62488

File No. _____
Registered No. 266
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Sister Mary Gertrude Hogan
(Usual place of abode) Bienville Court St. Ward St. Louis, Mo.

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1848

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
80 - -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Catholic Sister
(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) Ireland

PARENTS

10. NAME OF FATHER Thomas Hogan

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

12. MAIDEN NAME OF MOTHER Bridget McBreath

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

14. INFORMANT Mother Victoria
(Address) Boise & Clayton Rd

15. FILED 11/24, 1928 B. L. Jensen
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 24 1928

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 _____

THE CAUSE OF DEATH WAS AS FOLLOWS:

Senility
186A
1943
CONTRIBUTORY (SECONDARY) Senility
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH. No DATE OF _____

20. WAS THERE AN AUTOPSY? No

21. WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) [Signature], M. D.
, 19 (Address) University of Missouri

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Cemetery 11-26 1928

20. UNDERTAKER

Arthur J. Donnelly 2039 Wash St

Community

330-5

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County St. Louis Registration District No. 1170 File No. _____
 Township Central Primary Registration District No. 6248 Registered No. 266
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Sister Mary Gertrude Hogan
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W (write the word)

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. _____

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 1/16 19 29 C. L. Juwan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 24 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ also on _____, 19____, and that death occurred, on the date and above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicemia
Fell on floor in home
 (duration) _____ yrs. mos. da.
 CONTRIBUTORY Fracture of femur
 (SECONDARY) (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRIBUTED
 IF NOT AT PLACE OF DEATH? _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Her A. F. Coughlin, M. D.
 _____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-38148