

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

Do not use this space.

9097

1. PLACE OF DEATH

County Saline
Township _____
City Marshall (No. _____)

Registration District No. 796
Primary Registration District No. 3038

File No. _____
Registered No. 48
St. _____ Ward _____

2. FULL NAME Thomas E. Hogge

(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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mattie Hogge</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Nov 22 - 1875</u>		
7. AGE <u>53</u>	YEARS <u>3</u>	MONTHS <u>2</u>
		DAY <u>2</u>
If LESS than 1 day, _____ hrs. or _____ min.		

8. OCCUPATION OF DECEASED

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

PARENTS	10. NAME OF FATHER <u>Wm A. Hogge</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>
	12. MAIDEN NAME OF MOTHER <u>Catherine Shade</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>

14. INFORMANT J. P. Hogge
(Address) Marshall Mo

15. FILED 3/5 1929 McJohn H. McGuire
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 24 1929

17. I HEREBY CERTIFY, That I attended deceased from 1/30/28 to 2/24, 1929, that I last saw him alive on 2/24, 1929, and that death occurred, on the date stated above, at 2 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septic Endocarditis
763
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Acute Articular Rheumatism
(SECONDARY) (duration) _____ yrs. _____ mos. 28 ds.

18. WHERE WAS DISEASE CONTACTED? _____
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) H. P. Cunniff, M. D.
2/24, 1929 (Address) Marshall Mo.

*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 <u>Town Rock Cave</u>	DATE OF BURIAL <u>Feb 26 1929</u>
20. UNDERTAKER <u>R. W. Campbell</u>	ADDRESS <u>Marshall</u>

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAR 27 1929

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