

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

Do not use this space.

10435

1. PLACE OF DEATH

County..... Registration District No. 701
 Township..... Primary Registration District No. 1005
 City St Louis (No. 48 Kingsbury Place) St. _____ Ward _____

File No. _____
 Registered No. 2417
 St. _____ Ward _____

2. FULL NAME

Dobbia Hogan BOGHER.
 (a) Residence. No. 148 Kingsbury Place Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</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>Simon L. Bogher</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>August 11th 1939</u>		
7. AGE <u>90</u>	YEARS <u>6</u>	MONTHS <u>28</u>
		DAYS <u>28</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 9 1930
 17. I HEREBY CERTIFY, That I attended deceased from MAR 7th, 1930, to MAR 9th, 1930, that I last saw h. ex alive on MAR 8th, 1930, and that death occurred, on the date stated above, at 3 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia Acute
 10435
 _____ (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 100%
 _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? NO DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) M. D. Jennings, M. D.
Mar. 9, 1930 (Address) 110 Washington Blvd.

*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 Bellefontaine DATE OF BURIAL March 10 1930
 20. UNDERTAKER Wagoner Rud Co ADDRESS 362 Olive

9. BIRTHPLACE (CITY OR TOWN) Alton Ills.
 (STATE OR COUNTRY)
 10. NAME OF FATHER JOHN HOGAN
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Mary Mitchell West
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Virginia
 (STATE OR COUNTRY)
 14. INFORMANT Lawrence Bogher
 (Address) 6247 Wading Waters
 15. FILED _____ 19 _____
Wm C Stankoff REGISTRAR

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.

2
256
25

WRITE PLAINLY, WITH OMISSION OF UNNECESSARY DETAILS

