

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

Do not use this space.

33037

1. PLACE OF DEATH

County.....**Jackson**
Township.....**Kaw**
City.....**Kansas City**

Registration District No.....**399**
Primary Registration District No.....**1002**
(No. **4023 Terrace**)

File No.....
Registered No. **4257**
St. Ward)

2. FULL NAME Daniel Hoagland.

(a) Residence. No.....**4023 Terrace.** St., **7** 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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.	4. COLOR OR RACE Wh.	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married.
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5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
Lillian Hoagland.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Mch. 13. 1857.**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	73	7	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....**Blacksmith.**
(b) General nature of industry, business, or establishment in which employed (or employer).....**Retired.**
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN).....**New Jersey.**
(STATE OR COUNTRY)

10. NAME OF FATHER.....**George Hoagland.**

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....**U.S.A.**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER.....**Eva Michaels.**

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

14. INFORMANT.....**Mrs. Lillian Hoagland.**
(Address) **4023 Terrace. K.C. Mo.**

15. FILED.....**10/21/30 M. M. Kerowe**
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct. 21. 1930**

17. I HEREBY CERTIFY, That I attended deceased from 10-19-30
..... 19....., to **10-22-**..... 19**30.**
that I last saw him..... alive on **10/20/30**..... 19....., and that death occurred, on the date stated above, at **5:50 A.**..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage
97
(duration)..... yrs..... mos. **3** ds.

CONTRIBUTORY (SECONDARY) **Arterio-sclerosis**

unknown (duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED

1944
IS NOT AT PLACE OF DEATH.
DATE AND CATHETER RELEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS? **Clinical findings**
(Signed).....**Wesley Faust**..... M. D.
10/21/1930 (Address) **Kansas City, Kansas.**

*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 Memorial Park.	DATE OF BURIAL 10/23/1930
20. UNDERTAKER Gates Funeral Home	ADDRESS K.C.Ks.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

