

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

Do not use this space.

36344

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Carroll Primary Registration District No. _____
City Kansas City 1223 E. 10th

File No. _____
Registered No. 4854
St. _____ Ward) _____

2. FULL NAME

Charles M Hoagland
(a) Residence. No. 1223 E. 10th St., 2 Ward. (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. cs.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OF (OR) WIFE OF Lottie Bell Hoagland

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 8, 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 8 14

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Switchtender
(b) General nature of industry, business, or establishment in which employed (or employer) KC Terminal
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.

10. NAME OF FATHER James Hoagland

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

12. MAIDEN NAME OF MOTHER Martha

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

14. INFORMANT. Mrs Lottie Bell Hoagland
(Address) 1223 E. 10th

15. FILED 1/24 1930 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 22 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1930 to Nov 20 1930 that I last saw him alive on Nov 19 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Asymptotic Pneumonia
73
107A

CONTRIBUTORY (SECONDARY) Myocarditis, Chronic
(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? No

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) H. S. Kellogg M. D.

1/23 1930 (Address) 3046 Main R. C. M

*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

Cremation Nov 25 1930

20. UNDERTAKER ADDRESS D. H. Newcomer's Sons KC Mo

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.

3046 main