

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

Do not use this space.

40152

**1. PLACE OF DEATH**

County Moniteau  
 Township Burris Ford  
 City..... (No..... Ward)

Registration District No. 576  
 Primary Registration District No. 5774

File No.....  
 Registered No. 8  
 St..... Ward)

**2. FULL NAME**

Harald K. Hogsett

(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. 1 mos. 26 da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 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) Oct 14 1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
1 26

**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) Eron Mo  
 (STATE OR COUNTRY) R-1

PARENTS

10. NAME OF FATHER Harald Hogsett

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Eron Mo R-1

12. MAIDEN NAME OF MOTHER Nellie Scott

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Eron mo R-1

14. INFORMANT Harald Hogsett  
 (Address) Eron mo R-1

15. FILED 12-10-30 W. H. Pink REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 9th 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 8, 1930, to Dec 10, 1930.  
 that I last saw him alive on Dec 9th, 1930, and that death occurred, on the date stated above, at 10 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Double Lobar Pneumonia  
108  
157 (duration) yrs. mos. 5 da.

CONTRIBUTORY Premature Birth  
 (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....  
 (DID AN OPERATION PRECEDE DEATH..... DATE OF.....)

19. WHAT TEST CONFIRMED DIAGNOSIS.....  
 (Signed) E. S. Glover, M. D.  
 , 19 (Address) Russellville 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 Gray Cemetery DATE OF BURIAL Dec 11 1930

20. UNDERTAKER None ADDRESS

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.

DEC 23 1930

