

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.

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

Do not use this space.

MAY 25 1934

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City _____ (No. **2715 Madison**)

14213
File No. _____
Registered No. **3360**
St. _____ Ward _____

2. FULL NAME

Joan Hogan
(a) Residence, No. **2715 Madison St.**, **20** 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 *Female* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single*
(Write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **1-31-34**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
2 3

8. Trade, profession, or particular kind of work done, as splinner, sawyer, bookkeeper, etc. *None*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) *St Louis*
(STATE OR COUNTRY) *Mo*

13. NAME *Frank E. Hogan*

14. BIRTHPLACE (CITY OR TOWN) *Missouri*
(STATE OR COUNTRY)

15. MAIDEN NAME *May R. Scullen*

16. BIRTHPLACE (CITY OR TOWN) *Missouri*
(STATE OR COUNTRY)

17. INFORMANT *Frank Hogan*
(ADDRESS) *2715 Madison*

18. BURIAL, CREMATION, OR REMOVAL
PLACE *Calvary* DATE **4-4**, 19**34**

19. UNDERTAKER *Southern*
(ADDRESS) *6322 S. Grand*

20. FILED **MO - 3 1934**
J. Bredeck
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **4-3**, 19**34**

22. I HEREBY CERTIFY, That I attended deceased from *March 26*, 19**34**, to *April 3*, 19**34**

I last saw her alive on *April 13*, 19**34**. Death is said to have occurred on the date stated above, at **5 A.** m.

The principal cause of death and related causes of importance were as follows:
Bronchial Pneumonia Date of onset *3/27/34*

Other contributory causes of importance:
107a

Name of operation _____ Date of _____
What test confirmed diagnosis? *Clinical* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19**_____**

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) *Wm Noel*, M. D.
(Address) *2709 Cass*

Dr. No. 4744

14213

3360

St Louis

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Joan Hagan
Who died at _____ on Apr 3 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex ♀ Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 0 Months 2 Days 3

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) Aroneho pneumonia
Birthplace of father (State or country) _____
Birthplace of mother (State or country) Primary
Principal cause of death: no other cause

Other contributory causes of importance _____
Name of operation _____ Date of 107a _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician A M Krall
Address of physician _____

Signature of Registrar [Signature] Date filed 11-8-34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. _____ Very truly yours,

Primary Reg. Dist. No. _____

E. T. McLaugh
State Registrar
Special Agent.

S-14213