

16 MAR 17 1939

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

6388
Do not use this space.

1. PLACE OF DEATH *Dent*
 (a) County *Dent* Registration District No. *266*
 (b) Township *Salem mo* Primary Registration District No. *4164* Registered No. *13*
 (c) City *Salem mo* (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *David F. Hogan*
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 12 - 1865*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 10 21

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Farmer*
 9. Industry or business in which work was done, as 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) (STATE OR COUNTRY) *Crawford Mo*

FATHER 13. NAME *James Hogan*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Dont know*

MOTHER 15. MAIDEN NAME *Malinda Todd*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Dont know*

17. INFORMANT (ADDRESS) *Jane Hogan Salem mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *cedar knove* DATE *2/24* 1939

19. FUNERAL DIRECTOR (ADDRESS) *N. W. Holton Salem mo*

20. FILED *Feb 24 1939* *F. E. Butler md* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *February 3 1939*

I HEREBY CERTIFY That I attended deceased from *February 1 1939* to *February 3 1939*
 last saw him alive on *February 2 1939*. Death is said to have occurred on the date stated above, at *12:10 P.* m.
 The principal cause of death and related causes of importance were as follows:
Bronchial Pneumonia

Date of onset *2-1-39*

Other contributory causes of importance: *Chronic myocarditis*

Name of operation _____ Date of _____
 What test confirmed diagnosis? *Clinical Findings* Are 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? *No*
 If so, specify _____ (Signed) *F. E. Butler*, M. D.
 (Address) *Salem Missouri*

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.

STATEMENT BY LICENSED EMBALMER

I, N. D. Hobson, Licensed Embalmer No. 928
not hereby certify that the body recorded on the reverse side of this certificate was embalmed by at all

..... L. E.
No. or by, Registered Apprentice No.
working under my personal supervision.

Signed N. D. Hobson
Licensed Embalmer No. 928

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)