

FILED APR 12 1940

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
 STANDARD CERTIFICATE OF DEATH  
 1002

State File No. 9528

FILED MAR 12 1940

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 962

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Joseph Hospital  
 (If in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 12 days (Specify whether  
 In this community Life years, months or days)

3. (a) PRINT FULL NAME Thomas J. Hogan

3. (b) If veteran, name war World War 3. (c) Social Security No. no

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 27, 1894  
 (Month) (Day) (Year)

8. AGE: 45 Years 6 Months 1 Days If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Independence Mo  
 (City, town, or county) (State or foreign country)

10. Usual occupation Restaurant operator

11. Industry or business \_\_\_\_\_

12. Name John J. Hogan

13. Birthplace Kenn.  
 (City, town, or county) (State or foreign country)

14. Maiden name Sarah Lynch

15. Birthplace Independence Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Catherine Hogan

(b) Address 315 No. Pleasant

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/40  
 (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Indep. Mo

18. (a) Signature of funeral director George C. Calson 361  
 (b) Address Independence Mo.

19. (a) Mch 1, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Independence  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 315 No. Pleasant  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28  
 year 1940 hour 8:10 minute A. M.

21. I hereby certify that I attended the deceased from 2/15, 1940, to 2/28, 1940  
 that I last saw him alive on 2/28, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial (Bilateral) Pneumonia

Due to Ch. Nephritis 131

Due to Ch. Myocarditis

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 1

23. Signature William M.D. (M. D. or other)  
 Address 10307 Indep. Ave Date signed 3/1/40

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Raymond Martin, Registered Apprentice No. 199 working under my personal supervision.

Signed Frank Lewis

Licensed Embalmer No. 2467

P. O. Address Independence, Mo

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.)

If this body is not embalmed, above space should be left blank.