

No. 2
-11-10-39
5-17-39
I X FILED

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

42373
State File No. _____

JAN 25 1940

Registration District No. 266

Primary Registration District No. 5320

Registrar's No. 91

1. PLACE OF DEATH:

(a) County Dent

(b) City or town Springbrook Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: XXX
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution XXXX (Specify whether)

In this community Most of her life years, months or days 2

8. (a) PRINT FULL NAME Miranda Lucy E. Hogan

8. (b) If veteran, name war XX

3. (c) Social Security No. XX

4. Sex female 5. Color or race white

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife William Hogan

6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased Aug 19 - 1861
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	79	4	9hr.min.

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

10. Usual occupation housewife

11. Industry or business XX

MOTHER FATHER { 12. Name Jim Reeves

18. Birthplace XXXX XX
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Hogan

(b) Address Salem Mo

17. (a) burial (b) Date thereof 12-30-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cedar Grove em

18. (a) Signature of funeral director Carl Spencer

(b) Address Salem Mo

19. (a) 12-30-40 (b) T. E. Butler, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. XXXX (If rural, give location)

(e) If foreign born, how long in U. S. A.? XXX years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 28
year 1940 hour 12 minute 30 p.M.

21. I hereby certify that I attended the deceased from Dec 24, 1940 to Dec 28, 1940
that I last saw her alive on Dec 27, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Right T. Infarct

Due to Influenza

Due to 11W

Other conditions 11W
(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) na

(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?
240 (Specify type of place) (4) Means of injury ✓
While at work? ✓

23. Signature J. G. Dickey (M. D. or other)
Address Salem Mo Date signed Dec 29 40

Duration 6 days

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

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

RECEIVED

District Health Officer, No. 5_R

District File Number 14165

Date Filed _____

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~~ _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. 3806

P. O. Address Salem, 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.