

No. 2
4-13-40
5-17-39
I X23159

FEB FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1376
336

State File No. _____
Registrar's No. _____

Registration District No. 399

Primary Registration District No. 1002

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

1. PLACE OF DEATH: Jackson
(a) County _____
(b) City or town Kansas City
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution About 5 days
In this community All of her life
(Specify whether years, months or days)

3. (a) PRINT FULLNAME Mrs. Grace Anna Hogrefe
3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Clifford Hogrefe 6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased July 2 1888
(Month) (Day) (Year)

8. AGE: Years 52 Months 6 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace Kansas City, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name William T. Barker
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Angie McHold
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Clifford Hogrefe
(b) Address 4100 Holly

17. (a) burial (b) Date thereof 1/23/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director R. V. Lindsey & Sons
(b) Address 3911 Broadway

19. (a) Jan 23 1941 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 4100 Holly
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 21
year 1941 hour 11:35 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from Nov, 1940, to 1-21, 1941,
that I last saw her alive on 1-21, 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death Perforation of sigmoid colon with acute generalized peritonitis.
Due to 123-1

Other conditions Fibromyoma of uterus non-malignant
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy same

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

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 0

23. Signature H. P. Carhart M.D. (M. D. or other) _____
Address 925 Olive Blvd Date signed 1-21-41

JUN 5 1954

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 *James Keeler*

Licensed Embalmer No. 3738

P. O. Address *W. H. ...*

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, fact should be so stated above.