

FILED MAR 25 1941

Registration District No. 266

Primary Registration District No. 4164

Registrar's No. 20

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

1. PLACE OF DEATH

(a) County Salem, Kent Co.  
(b) City or town Salem  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: U.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 50 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Kent 33  
(c) City or town Salem 1  
(If outside city or town limits write "RURAL") 1  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27  
year 1941 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from Feb 26  
\_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw her alive on Feb 26, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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? \_\_\_\_\_

23. Signature P. E. Joffe (M. D. or other) Phys  
Address Salem, Mo. While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
Date signed 3/1/41

3. (a) PRINT FULL NAME Hattie Jane Hogan

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced W. 9

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

7. Birth date of deceased 7 30-1868  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
72 6 27 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

12. Name Sara Jane Ayers

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

14. Maiden name David Pulow

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

16. (a) Informant Kelly Bartlett

(b) Address Salem, Mo.

17. (a) \_\_\_\_\_ (b) Date thereof 2-28-41  
(Burial, cremation or removed) (Month) (Day) (Year)

(c) Place: burial or cremation Cedar Grove

18. (a) Signature of funeral director Robert Chantler

(b) Address Salem, Mo.

19. (a) 3-1-41 (b) P. E. Joffe M.D.  
(Date received local registrar) (Registrar's signature)

RECEIVED  
C. A. S. Health Officer No. 5,  
District File Number 341399  
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 \_\_\_\_\_

*N. D. Johnson*

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*N. D. Johnson*

Licensed Embalmer No. \_\_\_\_\_

*Salem mo.*

P. O. Address \_\_\_\_\_

*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.)

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