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FILED JUN 10 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17110

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1772

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 1223 West 47th Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ---
(Specify whether years, months or days)

In this community 52 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8

(d) Street No. 1223 West 47th Street
(If rural, give location)

(e) If foreign born, how long in U. S. A. --- years. 0

3. (a) PRINT FULL NAME Julian L. Hoagland

3. (b) If veteran, name war ---

3. (c) Social Security No. 486-01-224

4. Sex Male () 5. Color or race White

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

6. (b) Name of husband or wife Bernice Hoagland

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased February 14 1889
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>2</u>	<u>20</u>	hr. <u>---</u> min. <u>---</u>

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

10. Usual occupation Manager-Secretary

11. Industry or business Racket Merchandise Company

MOTHER FATHER {

12. Name Daniel Hoagland

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

14. Maiden name Lillie De Page

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

16. (a) Informant Mrs. Bernice Hoagland

(b) Address 1223 West 47th, K.C. Mo.

17. (a) Burial (b) Date thereof 5/6/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director [Signature]

(b) Address [Address]

19. (a) May 5, 1941 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4 year 1941 hour 9 minute 35 P.M.

21. I hereby certify that I attended the deceased from 3-28, 1941, to 5-4, 1941; that I last saw him alive on 5-4, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Central nervous system lues.

Due to 30

Due to 30

Other conditions 30
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: ---

Of operations ---

Of autopsy ---

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 ---

23. Signature [Signature] (M. D. or other) 0

Address [Address] Date signed 5-5-41

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

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

D Ross Blanford

Licensed Embalmer No.

4015

P. O. Address

41 + State Line

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

If this body is not embalmed, fact should be so stated above.