

See also 27224-42
 MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

State File No. **21346**

JUL 25 1941

Registration District No. **384**

Primary Registration District No. **5575**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Howell**
 (b) City or town **West Plains Rt 21**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Howell Hosp**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **27 years** (Specify whether
 in this community years, months or days)

3. (a) PRINT FULL NAME **Margaret 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**

6. (b) Name of husband or wife **Augustine Hogan** 6. (c) Age of husband or wife if alive **85** years

7. Birth date of deceased **10-17-1858**
 (Month) (Day) (Year)

8. AGE: Years **83** Months **1** Days _____ If less than one day hr. _____ min.

9. Birthplace **New Hamburg MO**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Louis Bucher**

13. Birthplace **unk 19**
 (City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant **Agu Hogan**

(b) Address **West Plains, MO**

17. (a) **B** (b) Date thereof **11-22-41**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Paph Cemetery**

18. (a) Signature of funeral director **Robertson**

(b) Address **West Plains, MO**

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Howell**
 (c) City or town **West Plains Mo 76**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) _____
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **20**
 year **1941** hour **5** minute **20** P.M.

21. I hereby certify that I attended the deceased from **Aug-9-**
41 to **Nov-20-**
41 that I last saw her alive on **Aug-9-**
41 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cancer of throat

Due to _____

Due to _____

Other conditions **None**
 (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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 _____

23. Signature **Robertson** (Name of other) _____

Address _____ Date signed _____

1125 (Licensed Embalmer's Statement on Reverse Side)

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

600

RECEIVED

District Health Officer No. 5,

District File Number 542372

Date Filed 7-20-42.

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. 3432

P. O. Address West Hill, N.Y.

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.