

34896

No. 2
5-43
5-42-59
1-2-3887

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

NOV 10 1943

Registration District No. 124

Primary Registration District No. 4234

Registrar's No. 47

1. PLACE OF DEATH:

(a) County Iron

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

(c) Name of hospital or institution:
St. Marys of the Graces
(If not in hospital or institution, write street number or location)

(d) Length of stay: 16 hospital or institution (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Wisconsin (b) County 9th

(c) City or town Milwaukee
(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 _____

3. (a) PRINT FULL NAME JOHN HOGAN

3. (b) If veteran, name war _____

3. (c) Social Security No. future

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 10
year 1943 hour 2 minute 10 P. M.

4. Sex Male 5. Color or race White Cauc

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

6. (b) Name of husband or wife Mary Barty Hogan

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

7. Birth date of deceased April 29-1889
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 4, 1943, to Oct 10, 1943; that I last saw him alive on Oct 10, 1943; and that death occurred on the date and hour stated above.

8. AGE: Years 64 Months 5 Days 11 If less than one day
hr. _____ min. _____

Immediate cause of death Carcinoma of stomach Duration 6 mos.

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

Due to _____

Due to _____

10. Usual occupation Retired fireman

Other conditions Chronic myocarditis
(Include pregnancy within 3 months of death)

11. Industry or business _____

PHYSICIAN

Major findings:
Of operations H6 L
Of autopsy _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name unknown

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

14. Maiden name _____

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

16. (a) Informant Mrs. Paul Ramsey (daughter)

(b) Address Flat River, Mo.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof Oct. 14-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Holy Cross Cemetery

(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 _____

18. (a) Signature of funeral director Alvin W. Wood

(b) Address 303 Crane St. Flat River, Mo.

19. (a) 10-14-43 (b) Virgus B. Miller
(Date received local registrar) (Registrar's signature)

23. Signature Ben W. Bull (M. D. or other) MD

Address Dronton, Mo. Date signed 10-11-43

1283

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 24 1944

RECEIVED

District Health Officer No. 4
District File Number 1143-2946
Date Filed 11-9-43

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..... *Alvin W. Hood*

Licensed Embalmer No. *2780*

P. O. Address *303 Crane St Flat River*

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.