

FILED OCT 7 1944  
Registration District No. **377**

Primary Registration District No. **3063**

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

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Chamanade College--Lindberg Drive  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 (Specify whether  
In this community 1 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County St. Louis  
(c) City or town Clayton  
(If outside city or town limits, write "RURAL")  
(d) Street No. Lindberg Blvd.  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Agnes Hogan

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Dennis J. Hogan 6. (c) Age of husband or wife if alive 81 years

7. Birth date of deceased Aug. 25, 1868  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
76 1 5 hr. min.

9. Birthplace St. Louis Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

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

MOTHER FATHER { 12. Name Patrick Hannon  
13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

{ 14. Maiden name Dont Know  
15. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Rev. Robert F. Hogan  
(b) Address Chamanade College

17. (a) Burial (b) Date thereof 10-4-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur Donnelly  
(b) Address 3840 Linden St

19. (a) OCT 3 1944 (b) E. B. McEwan M.D.  
(Date of medical certificate) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 1  
year 1944 hour 12 minute A. M.

21. I hereby certify that I attended the deceased from 9/30 1944 to 10/1 1944  
that I last saw her alive on 9/30 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy Duration 1 hr

Due to Hypertension

Due to 834

Other conditions \_\_\_\_\_  
(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 0

23. Signature J. D. Stauble M. D. or other M.D.  
Address 104 Williams, Richmond Date signed 10/2/44

102 Williams  
I-1  
Staeckle

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 W. Van Matr.

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.