

FILED NOV 30 1944  
318  
Registration District No.

Primary Registration District No.

1003

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
Mo. Baptist Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Mary McCormack Hogan

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced W. 2

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

7. Birth date of deceased Unk. Unk. 1870  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

abt - 74 Unk. Unk. \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation At Home

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

MOTHER FATHER { 12. Name Thomas McCormack

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

14. Maiden name Julia Quinn

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

16. (a) Informant Mrs. A.M. Ing

(b) Address 4516 McPherson Ave.

17. (a) Burial (b) Date thereof 11-24-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cathary

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) NOV 22 1944 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: Mo. (a) State Mo. (b) County 17

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 9 1/2

(d) Street No. 4516 McPherson Ave. (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 21st., year 1944 hour \_\_\_\_\_ minute 58 p. M.

21. I hereby certify that I attended the deceased from Nov. 16, 1944, to Nov. 21, 1944, that I last saw her alive on Nov. 21, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 6 days

Due to Cardio-vascular disease & hypertension 5 yrs.

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:

(c) 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) (c) Means of injury \_\_\_\_\_

23. Signature H. J. Wenne (M. D. \_\_\_\_\_)  
Address 315 University Bay Date signed 11/22/44

PHYSICIAN  
Underline the cause to which death should be charged statistically.

