

FILED FEB 17 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 655

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: K. C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days  
(Specify whether years, months or days)

In this community 5 mo

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")

(d) Street No. 1224 Harrison  
(If rural, give location) 8

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Mary Hogan

3. (b) If veteran, name war ✓

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February, day 9, year 1945 hour 6 minute 45 A.M.

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

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

7. Birth date of deceased: Dec 13 - 1879  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from January 31, 1945 to February 9, 1945 that I last saw her alive on February 9, 1945 and that death occurred on the date and hour stated above.

8. AGE: Years 65 Months 1 Days 27 If less than one day ✓ hr. ✓ min.

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

10. Usual occupation Retired

Immediate cause of death Bronchopneumonia 107  
Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 107  
(Include pregnancy within 3 months of death)

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

12. Name Daniel Hogan

13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

14. Maiden name Thorn McLean

15. Birthplace Canada 2  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_

Of autopsy None

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

16. (a) Informant Mrs. Daniel Hogan

(b) Address 609 E 9

17. (a) Removal (b) Date thereof Apr 9 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clarence Mo

18. (a) Signature of funeral director A. R. Doherty

(b) Address 1415 E 15

19. (a) 2-9-45 (b) D. E. Brown  
(Date received local registrar) (Registrar's signature)

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)

(a) Means of injury \_\_\_\_\_

23. Signature Clark Wisely M.D. (M. D. or other) 2-9-45

Address Med. Dir. Gen'l Hosp. Date signed \_\_\_\_\_

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

MOTHER FATHER

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**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..... *H. P. Doehler* .....

Licensed Embalmer No..... *1166* .....

P. O. Address..... *1415 E 15* .....

**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.**