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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 6 1946

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 10762

Registration District No. 377 Primary Registration District No. 6076 Registrar's No. 762

**1. PLACE OF DEATH:**
(a) County ST. LOUIS
(b) City or town LEMAY (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Rose Sanitorium (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 mo. (Specify whether years, months or days) In this community

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MISSOURI (b) County 000
(c) City or town ST LOUIS (If outside city or town limits, write "RURAL") 17
(d) Street No. 5960 OAKHERST PLACE (If rural, give location)
(e) Citizen of foreign country? (Yes or No) /
If yes, name country

3. (a) PRINT FULL NAME Lucille A Hogan.
3. (b) If veteran, name war NO
3. (c) Social Security No.
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 APRIL (Month) 17 (Day) 1896 (Year)

8. AGE: Years 49 Months 11 Days 14 If less than one day hr. min.

9. Birthplace ST. LOUIS (City, town, or county) (State or foreign country)
10. Usual occupation CLERK
11. Industry or business MISS. VALLEY TRUST CO
FATHER 12. Name JAMES HOGAN
13. Birthplace ST. LOUIS (City, town, or county) MISSOURI (State or foreign country)
MOTHER 14. Maiden name CLEMENTINE FOGEL
15. Birthplace GALENA (City, town, or county) ILLINOIS (State or foreign country)
16. (a) Informant Mrs C. Hogan
(b) Address 5960 Oakhurst Place
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof APRIL 3 - 46 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY CEM.
18. (a) Signature of funeral director E. J. Schnur
(b) Address 3125 Lafayette, Av.
19. (a) 4-3-46 (Date received by local registrar) (b) [illegible] (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Mar. day 31 year 1946 hour 5 minute 45 A.M.
21. I hereby certify that I attended the deceased from Feb 25, 1946, to Mar. 31, 1946 that I last saw him alive on Mar. 30, 1946 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic Heart Disease | uncertain |
| Due to Pleural effusion | 3 weeks |
| Due to Far advanced Pulmonary Tbc | uncertain |
| Due to | |
| 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Mayo Ohmstede (M. D. or other) M.D.
Address 9101 So. Broadway Date signed 3-31-46

(Licensed Embalmer's Statement on Reverse Side)

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

96
0
8

9674

## 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 Joseph B. Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 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.**