

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **387193**
 Registrar's No. **9848**

FILED DEC 2 1946
 Registration District No. **318**

Primary Registration District No. **1003**

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

37004

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:
4734 Thrush Ave.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mary 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 **Widowed**

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

7. Birth date of deceased **March 4th. 1866**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	80	8	13 hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business.....

MOTHER FATHER

12. Name **Edward Dooling**
Ireland
(City, town, or county) (State or foreign country)

13. Birthplace.....

14. Maiden name **Unknown**
Ireland
(City, town, or county) (State or foreign country)

15. Birthplace.....

16. (a) Informant **Grace Hynes**
4734 Thrush Ave.
 (b) Address.....

17. (a) **Burial** (b) Date thereof **II/20/46**
(Burial, cremation; or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Sullivan Funeral Dir**
 (b) Address **2849 North Euclid Ave.**

19. (a) **NOV 19 1946** (b) **J. F. Bredeek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **4734 Thrush 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 **17th**
 year **1946** hour **6.40** minute..... P.M.

21. I hereby certify that I attended the deceased from **November 17th** 19**46**, to **November 16, 1946**, that I last saw her alive on **November 16, 1946**, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Carcinoma large intestine
Due to Can. Cause Bronchial Asthma
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?.....

23. Signature **N. J. Honick** (M. D. or other).....
 Address **4951 Dursh** Date signed.....
(Specify type of place) (e) Means of injury.....

NOV 19 1946

(Licensed Embalmer's Statement on Reverse Side)

Dr. Nicholas Henich

4991 Thrush Ave. GO. 3100

Go 8830

Will call Ws.

W

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

Albert Fryfield

Licensed Embalmer No.

3077

P. O. Address

St. Louis Mo

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.