S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 16 1947

Registration District No. 170

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. S625

State File No. 1640

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Rural Auglaize
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community always
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede 53

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Leathie Green Hogue

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife H. H. Hogue

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased Sept (Month) 1 (Day) 1883 (Year)

8. AGE: Years 63 | Months 3 | Days ~~4~~ | If less than one day ..... hr. ..... min.

9. Birthplace Camden Co. (City, town, or county) V (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John Burns 0
13. Birthplace (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Martha J. Dickerson
15. Birthplace (City, town, or county) Tenn 1 (State or foreign country)

16. (a) Informant H. H. Hogue
(b) Address Hoyt Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/47 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Ark.

18. (a) Signature of funeral director Palmer
(b) Address Lebanon Mo.

19. (a) Jan 9, 1947 (Date received local registrar) (b) Ora Frankeberger (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 1 day ~~[illegible]~~ 1 year 1947 hour ..... minute P. M.

21. I hereby certify that I attended the deceased from Dec. 1, 1946, to Dec. 24, 1946 that I last saw her alive on Dec. 21, 1946; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Interstitial Nephritis - Chronic	1 yr.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 131B	

Major findings:
Of operations No operation
Of autopsy No 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 0

23. Signature E. L. C. Carbone (M. D. or other) M.D.

Address Camden Mo. Date signed 1-4-47

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(Licensed Embalmer's Statement on Reverse Side)

Received 1/14/47

Laclede County Health Unit

File No. 1-47-1

Date Filed 1/14/47

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 S. P. Palmer

Licensed Embalmer No. 2208

P. O. Address Lebanon 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.