

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

38787

State File No. ....

FILED DEC 2 1947  
Registration District No. ....

Primary Registration District No. 3626

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Rural Eldredge  
(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 Always (Specify whether years, months or days)

In this community Always (Specify whether 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. Wescaturville mo  
(If rural, give location)

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

3. (a) PRINT FULL NAME Joe P Hogue

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 12 year 1947 hour 7 minute 35 A.M.

4. Sex MO 5. Color or race W

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

6. (b) Name of husband or wife Hella Hogue 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Nov. 10 1982  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 1946 to Nov. 1947 that I last saw him alive on Nov. 11 1947 and that death occurred on the date and hour stated above.

8. AGE: Years 66 Months 0 Days 2 If less than one day hr. min.

9. Birthplace Laclede Co. mo  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

Immediate cause of death Angina Pectoris

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

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

Other conditions (include pregnancy within 3 months of death) 9410

MOTHER FATHER

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

12. Name Alexander Hogue

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

14. Maiden name Primilla Harrison

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

16. (a) Informant Clint Rogers

(b) Address Wescaturville

17. (a) Burial (b) Date thereof 12/19/47  
(Burial, cremation, or removal) (Monthly) (Day) (Year)

(c) Place: burial or cremation mt. Air.

18. (a) Signature of funeral director Palmer

(b) Address Lebanon mo

19. (a) Nov. 22 1947 (b) Des. Humberger  
(Date received local registrar) (Registrar's signature)

Major findings: None Operation

Of operations \_\_\_\_\_

Of autopsy No Autopsy

PHYSICIAN \_\_\_\_\_

Underline the cause of 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? \_\_\_\_\_ (b) Means of injury \_\_\_\_\_

23. Signature E. S. Robinson (Registrar)

Address Camden mo Date signed 11-14-47

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

Received 12/1/47  
Taslede County Health Unit  
File No. 11-47-203  
Date filed 12/1/47

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 \_\_\_\_\_

working under my personal supervision. \_\_\_\_\_ Registered Apprentice No. \_\_\_\_\_

Signed *Nat Embalmed* \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.