. S. No. 2
OM—1/47
ev. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40529

FILED DEC 8 1947

Registration District No. 7

Primary Registration District No. 6076

Registrar's No. 2460

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 87 days (Specify whether
In this community 16 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 2813 N. Kingshighway 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME LOGAN, OPAL PEARL
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female 3
5. Color or race Negro
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased February (Month) 28 (Day) 1928 (Year)

8. AGE: Years 19 Months 80 Days 27 If less than one day hr. min.

9. Birthplace Earl (City, town, or county) Arkansas (State or foreign country) 1
10. Usual occupation Nil
11. Industry or business

FATHER
12. Name Will Logan
13. Birthplace ?? (City, town, or county) ?? (State or foreign country) 9

MOTHER
14. Maiden name Carrie Gill
15. Birthplace ?? (City, town, or county) ?? (State or foreign country) 9

16. (a) Informant Hospital Records
(b) Address Robert Koch Hospital
17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 11-28-47 (Month) (Day) (Year)
(c) Place: burial or cremation EARL ARK.
18. (a) Signature of funeral director H. W. Bruce
(b) Address 4469 Washington Ave.
19. (a) 11-28-47 (Date received local registrar) (b) Carl C. Sharp (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 24
year 1947 hour 5 minute 28 A.M.

21. I hereby certify that I attended the deceased from 8-29- 1947, to 11-24- 1947;
that I last saw her alive on 11-24- 1947;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	1½ yrs. (??)
Due to	
Due to 13 b	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of 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? (e) Means of injury 0

23. Signature Bernard Friedman (M. D. or other) MD
Address Robert Koch Hospital Date signed 11/24/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Frederick P. Stark Registered Apprentice No. 74, working under my personal supervision.

Signed Melvin E. Green

Licensed Embalmer No. 4428

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.