

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003State File No. **27822**
Registrar's No. **7036**FILED AUG 23 1948
Registration District No. **18**

Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo; 28 days
35 yrs (Specify whether
in this community _____
years, months or days)

3: (a) PRINT
FULL NAMEHarry Hogan3. (b) If veteran,
name war #1

3. (c) Social Security No. _____

4. Sex Male 2
5. Color or race Colored
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ollie Mae Hogan
6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased Sept. 20, 1897
(Month) (Day) (Year)

8. AGE: Years 50 Months 20 Days 16
If less than one day
hr. _____ min. _____

9. Birthplace E. St. Louis, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business

12. Name Sam Hogan
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Bettie Talley
15. Birthplace Clarksville Tenn. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Bettie Dixon (Mother)(b) Address 3636 Page Blvd

17. (a) Burial (b) Date thereof 8-11-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park, Ceme.18. (a) Signature of funeral director Peoples Und, Co.(b) Address 3100 Franklin Avenue19. (a) AUG 11 1948

(Date received local registrar)

(b) J. F. Bredes
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 2416 N Whittier 6
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 6
year 1948 hour 10 minute 25 A.M.

21. I hereby certify that I attended the deceased from
June 9, 1948, to August 6, 1948;
that I last saw h. im alive on August 6, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death

Carcinoma of the Lung with Metas-
tases

Duration

Unk

Due to _____

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 sta-
tistically.

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? _____

While at work _____

(Specify type of place)

(e) Means of injury _____

23. Signature J. F. Daniels (M. D. or other) _____Address 2601 N Whittier Date signed 8-6-48

(Licensed Embalmer's Statement on Reverse Side)

SEP 27 1948

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

John H. Peters
- Licensed Embalmer No. *4184*
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.