

FILED OCT 27 1948

STANDARD CERTIFICATE OF DEATH

State File No. 32524

Registration District No. 113

Primary Registration District No. 4185

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town Franklin
(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. 83 years
years, months or days

Full name Caroline Wall

3. (b) If veteran, - 3. (c) Social Security No. -
name war.

4. Sex female 5. Color of w 6. (a) Single () widowed, married, divorced ()

6. (b) Name of husband or wife James Hogan 6. (c) Age of husband or wife If

7. Birth date of deceased 9-14-1869
(Month) (Day) (Year)

8. AGE: 83 Years Months 10 Days If less than one day

9. Birthplace Algiers
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business

12. Name James Hogan

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

14. Maiden name Baker

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

16. (a) Informant W. E. King

(b) Address St. Clair

17. (a) Burial (b) Date thereof 9-28-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation W. E. King

18. (a) Signature of funeral director W. E. King

(b) Address St. Clair

19. (a) 9-28-48 (b) W. E. King
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin
(c) City or town St. Clair
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28
year 1948 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from 6-14-48 to 9-21-48
that I last saw him alive on 9-21-48
and that death occurred on the date and hour stated above

Immediate cause of death Cancer of Liver

Due to Pituitary passage

Due to

Other condition Arterial Hypertension
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 16

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

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?

Without work? (Specify type of force) (e) Means of injury

23. Signature W. E. King (M. D. or other)

Address St. Clair Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

6 TON RECORDS

-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.

Licensed Embalmer No. 3873

P. O. Address 4141 1/2 Ave. S.W.

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.