

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32934**
Registrar's No. **3951**

FILED NOV 4 1948
Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution: **4017 Main Street**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(d) Street No. **4017 Main Street**
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **Charles F. Hogue**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **491-22-4439**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept.** day **28th.** year **1948** hour **2:15** minute **P** M.

4. Sex **Male**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Mrs. Frances Hogue**
6. (c) Age of husband or wife if alive **24th.** years **1858**

21. I hereby certify that I attended the deceased from **10/31/46** to **9/28/48**
that I last saw him alive on **June** 19**48** and that death occurred on the date and hour stated above.

7. Birth date of deceased: **January 24th. 1858**
(Month) (Day) (Year)
8. AGE: Years **90** Months **8** Days **4**
If less than one day hr. min.

Immediate cause of death: **Rupture of aneurysm of abdominal aorta**
Due to **Atherosclerosis**
Duration **2+ years**

9. Birthplace **Mommouth (Warren Co.) Ill.**
(City, town, or county) (State or foreign country)
10. Usual occupation **At Home**

Other conditions (Include pregnancy within 3 months of death) **92**

MOTHER FATHER
11. Industry or business
12. Name **John N. Hogue**
13. Birthplace **Illinois**
14. Maiden name **DON'T KNOW**
15. Birthplace **Don't Know**

Major findings: Of operations
Of autopsy **Above; Congenital cysts of kidney; Cardiac Hypertrophy**
PHYSICIAN Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Bessie MacKenzie**
(b) Address **4017 Main Street**
17. (a) **Removal** (b) Date thereof **10-1-48**
(c) Place: burial or cremation **Hutchinson, Kansas**
18. (a) Signature of funeral director **Freeman Mortuary**
(b) Address **Kansas City, Missouri**
19. (a) **1-29-48** (b) **Gerardine Holman**
(Date received local registrar) (Registrar's signature)

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work (Specify type of place) (b) Means of injury
23. Signature **W. H. Hurdon, MD** (M. D. or other)
Address **Kansas City, Mo** Date signed **9/29/48**

730 Post 139

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 Walter H. Erwin

Licensed Embalmer No. 4352

P. O. Address Kansas City, 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.