

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35233

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9276

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>St. Louis |  | a. STATE Missouri b. COUNTY   |  |
| c. LENGTH OF STAY (in this place)   |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>St. Louis     |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br>De Paul Hospital                       |  | d. STREET ADDRESS (If rural, give location)<br>5410 West Florissant                   |  |

|  |                           |   |                                       |   |                         |                              |                         |                        |
|--|---------------------------|---|---------------------------------------|---|-------------------------|------------------------------|-------------------------|------------------------|
| 3. NAME OF DECEASED (Type or Print)  |                           |   | 4. DATE OF DEATH (Month) (Day) (Year) |   |                         |                              |                         |                        |
| a. (First) Esther  |                           |   | b. (Middle)                           |   |                         |                              |                         |                        |
| c. (Last) Hogan  |                           |   | 7/10/26/49                            |   |                         |                              |                         |                        |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>Married | 8. DATE OF BIRTH<br>7/15/1883         | 9. AGE (In years less birthday)<br>76                       | 10. UNDER 1 YEAR Months | 11. UNDER 14 HRS. Days       | 12. UNDER 14 HRS. Hours | 13. UNDER 14 HRS. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife |                           | 10b. KIND OF BUSINESS OR INDUSTRY                                 |                                       | 11. BIRTHPLACE (State or foreign country)<br>St. Louis, Mo. |                         | 12. CITIZEN OF WHAT COUNTRY? |                         |                        |

|  |  |                                      |  |  |  |
|--|--|--------------------------------------|--|--|--|
| 13a. FATHER'S NAME<br>Aaron Block  |  | 13b. MOTHER'S MAIDEN NAME<br>Unknown |  | 14. NAME OF HUSBAND OR WIFE<br>William P. Hogan                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO.              |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br>William P. Hogan 5410 W. Florissant |  |

|   |  |                                  |  |                |
|---|--|----------------------------------|--|----------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cardiovascular renal disease</i>   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><i>5 yrs</i> |                |
|   | ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <i>Arteriosclerosis</i> |                                  |  | <i>5 yrs?</i>  |
|   | DUE TO (c) <i>Cardiac failure</i>  |                                  |  | <i>3 weeks</i> |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION |  |                |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)               |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)<br><i>91</i> |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?<br><i>Hit</i>                     |  |

22. I hereby certify that I attended the deceased from *9/29, 1949*, to *10/26, 1949*, that I last saw the deceased alive on *10/26, 1949*, and that death occurred at *5:15 p.m.*, from the causes and on the date stated above.

|   |  |                                     |  |  |  |
|---|--|-------------------------------------|--|--|--|
| 23a. SIGNATURE (Degree or title)<br><i>Norman Kane MD</i>       |  | 23b. ADDRESS<br><i>1117 N Grand</i> |  | 23c. DATE SIGNED<br><i>Oct 27/49</i>                   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial             |  | 24b. DATE<br>10/29/49               |  | 24c. NAME OF CEMETERY OR CREMATORY<br>Calvary Cemetery |  |
| 24d. LOCATION (City, town, or county) (State)<br>St. Louis, Mo. |  |                                     |  |  |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| DATE REC'D BY LOCAL REG.<br>OCT 28 1949 |  | REGISTRAR'S SIGNATURE<br><i>J. B. Fusater</i> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br>Sullivan Funeral Dir. 2849 N. Euclid |  |
|---|--|---|--|--|--|

(Licensed Embalmer's Statement on Reverse Side)

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

Handwritten mark resembling a large 'A' or 'X' with a diagonal line.

**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.

Student Embalmer No. \_\_\_\_\_

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*Gustav W. Dittely*

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

*4329*

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.