

FILED DEC 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38833**
Registrar's No. **10219**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY ABC	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS (If rural, give location) 5637 Kennedy	

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Edwin c. (Last) Hogan	4. DATE OF DEATH (Month) (Day) (Year) 11 27 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Oct 5, 1943	9. AGE (In years last birthday) 6 If under 1 year: Months _____ Days _____ If under 1 mo.: Weeks _____ Mths. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Graham W. Hogan	13b. MOTHER'S MAIDEN NAME Marie L. Apenbrink	14. NAME OF HUSBAND OR WIFE
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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 Graham Hogan-5637 Kennedy	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 22 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Post-operative hemorrhage following craniectomy. Convulsions. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Hypertrophic Nivellitis DUE TO (c) Adenoiditis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION 11/26/49	19b. MAJOR FINDINGS OF OPERATION: hyperthrophic Nivellitis and Adenoids.	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 115
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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? 5000
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22. I hereby certify that I attended the deceased from **11/25 1949** to **11/27 1949**, that I last saw the deceased alive on **11/24 1949** and that death occurred at **5:20 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Thomas Lawton M.D.	23b. ADDRESS 2739 N Grand	23c. DATE SIGNED 11/28/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-30-49	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. NOV 28 1949	REGISTRAR'S SIGNATURE J. B. Sarsate	25. FUNERAL DIRECTOR'S SIGNATURE Kraeger-Voss Funeral Home	ADDRESS 3400 No. 111st highway
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Robert M. Murray

Licensed Embalmer No. 3749

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.