

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

XC-None filed

Reg.# 88479

REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2234

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

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY ST. LOUIS | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) JEFF. ERKS, MO. | | c. CITY (If outside corporate limits, write RURAL and give township) JACKSONVILLE | |
| c. LENGTH OF STAY (In this place) 1 day | | d. STREET ADDRESS (If rural, give location) 807 E. Independence Avenue | |
| 3. NAME OF DECEASED (Type or Print) a. (First) RAYMOND | | b. (Middle) (NMI) | |
| c. (Last) HOGAN | | 4. DATE OF DEATH (Month) (Day) (Year) 9-19-50 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED | 8. DATE OF BIRTH 5-20-92 |
| 9. AGE (In years last birthday) 58 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | 11. BIRTHPLACE (State or foreign country) Jacksonville, Ill |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13a. FATHER'S NAME WILLIAM HOGAN | |
| 13b. MOTHER'S MAIDEN NAME CATHERINE COONEY | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI | | 16. SOCIAL SECURITY NO. 333013749 | |
| 17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS, JEFF. ERKS, MO. | | ADDRESS | |
| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | | 19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) GENERALIZED PERITONITIS CAUSE UNDETERMINED ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 5/6 X | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 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) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | 22. I hereby certify that I attended the deceased from 9-18-50 , 19___, to 9-19-50 , 19___, that the deceased died VA and that death occurred at 12:50P m., from the causes and on the date stated above. | |
| 23a. SIGNATURE L.E. Stowell | | 23b. ADDRESS VA HOSPITAL, JEFF. ERKS, MO. | |
| 23c. DATE SIGNED 9-19-50 | | 23d. DEGREE OR TITLE CHIEF, PROF. SVCS. | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 9/20/1950 | |
| 24c. NAME OF CEMETERY OR CREMATORY: 1 | | 24d. LOCATION (City, town, or county) (State) Jacksonville, Illinois | |
| DATE REC'D BY LOCAL REG. 9-20-50 | | REGISTRAR'S SIGNATURE Herbert R. Donko | |
| 25. FUNERAL DIRECTOR'S SIGNATURE ALBERT H. HOPPE, INC., St. Louis, Mo. | | ADDRESS | |

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 me

.....
working under my personal supervision.

Student Embalmer No.

Signed [Signature]

Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address. W. A. Charles, M

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.