

FILED APR 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13179
STATE FILE NUMBER
1385
REGISTRAR'S NO.

1672-0 94981-56 Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Catholic Hosp</u> Length of stay in <u>3 Mo</u> d. STREET ADDRESS (If outside give location) <u>1003 Spruce</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Dianna</u> Middle <u>Sue</u> Last <u>Hogan</u>			4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 12 30-56</u> IF UNDER 1 YEAR Month <u>3</u> Day <u>30</u> Year <u>1956</u> IF UNDER 24 HRS. Hours <u>10</u> Min. <u>45</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		9b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Kansas City Mo U.S.</u> IF BORN IN GREAT BRITAIN
13. FATHER'S NAME <u>John Hogan</u>		14. MOTHER'S MAIDEN NAME <u>Jessie Dixon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>John Hogan</u> Address <u>1003 Spruce</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> DUE TO (b) <u>meningitis - non specific</u> DUE TO (c) <u>Debility due Celiac disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Encephalites</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>3 months</u> <u>life</u> <u>186 D</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>Mar. 20, 1957</u> to <u>Mar. 23, 1957</u> and last saw her <u>alive</u> on <u>3-23-57</u> Death occurred at <u>10 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Myron D. Jones, D.O.</u>		22b. ADDRESS <u>926 E 11th St</u>	22c. DATE SIGNED <u>3-29-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-26-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	23d. LOCATION (City, town, or county) (State) <u>KC Mo</u>
24. FUNERAL DIRECTOR <u>St. B. Layette</u> ADDRESS <u>15 c. ma</u>		25. DATE RECD. BY LOCAL REG. <u>3-25-57</u>	26. REGISTRAR'S SIGNATURE <u>Gene Minshall</u>

Health, & Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Myron D. Jones

APR 14 03 83

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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.....
Signature of Student Embalmer

Signed *Bill B. Fitzgerald*

Licensed Embalmer No. *497*

P. O. Address *KC 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.