

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 19 1957

57 STATE FILE NUMBER 2510

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

300
-57

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|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) St. Mary's Hosp. | | Length of stay in lb 80 year | d. STREET ADDRESS (If outside, give location) 6024 Walnut Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First MAY Middle LORETTA Last HOGAN | | | 4. DATE OF DEATH Month May Day 29 Year 1957 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 9, 1877 |
| 9. AGE (In years last birthday) 80 | | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) Kansas City, Mo. |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13a. FATHER'S NAME James Burke | |
| 13b. MOTHER'S MAIDEN NAME Anna Mansfield | | 14. NAME OF HUSBAND OR WIFE Wm. Edward Hogan | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Rev. James G. Hogan, 52nd & Troost Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia | | | INTERVAL BETWEEN ONSET AND DEATH 2 wks |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) transitional Cell Carc of bladder with Pel. Metas | | | 1 yr |
| DUE TO (c) Bladder with Pel. Metas | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 181X | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 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 <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> | | | |
| 20d. INJURY OCCURRED WHILE AT <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 4-16-56 to 5-29-57 and last saw her alive on 5-28-57 Death occurred at 3:45 A m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Wm. A. Stagg M. D. | | (Degree or title) D | 22b. ADDRESS 1030 Maple K.C. Mo |
| 22c. DATE SIGNED 5-29-57 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 5-31-57 | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri |
| 24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home | | ADDRESS 1800 E. Linwood, K. C., Mo. | 25. DATE RECD. BY LOCAL REG. 5-29-57 |
| 26. REGISTRAR'S SIGNATURE Neva Marshall | | | |

All diseases in Part I must be causally related.

Wm. A. Stagg USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr. Wm. A. King
Angele Redy
No. 2-5618



1-30 PM - 5

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 *James P. McMillin Jr.*

Licensed Embalmer No. *4826*
P. O. Address *K. E. - 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.