

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

FILED OCT 4 1957

31925  
STATE FILE NUMBER  
4239  
Registrar's No.

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <b>VA HOSPITAL</b>		Length of stay in lb <b>40 years</b>	d. STREET ADDRESS (If outside, give location) <b>1300 WASHINGTON</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>OMA C. HOGAN</b>			4. DATE OF DEATH Month Day Year <b>September 10, 1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 21, 1884</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	9c. AGE (In years last birthday) <b>73</b> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and state or country) <b>Otterville, Missouri</b>
13a. FATHER'S NAME <b>Robert Hogan</b>		13b. MOTHER'S MAIDEN NAME <b>Laura McCutchin</b>	14. NAME OF HUSBAND OR WIFE <b>Ella</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWT</b>		16. SOCIAL SECURITY NO. <b>496-09-3305</b>	17. INFORMANT Address <b>VA Hospital Official Records, K. C. Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } * DUE TO (b) <b>Massive retroperitoneal hemorrhage</b> DUE TO (c) <b>Infiltrating transitional cell carcinoma,</b> <b>Urinary bladder</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).			INTERVAL BETWEEN ONSET AND DEATH <b>1817</b>
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. PLACE OF INJURY (e.g., in or about home, farm, factory; street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>September 8, 1957</b> to <b>September 10, 1957</b> Death occurred at <b>10:00 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>A. J. WILLIAMS, M.D. A.J. Williams</b>		22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>	
22c. DATE SIGNED <b>9-10-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>SEPT. 12, 1957</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>	
24. FUNERAL DIRECTOR ADDRESS <b>D.W. NEWCOMER'S SONS, KANSAS CITY, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>9-11-57</b>	
		26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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

*Basil V. Arney*

Licensed Embalmer No. *4724*

P. O. Address *N.C. Me*

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.