

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030532

STATE FILE NUMBER 8042

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

FILED AUG 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8042

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>JEFFERSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR <u>ST. LOUIS</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>DeSoto RT. #3</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb <u>40 HOSPITAL OR INSTITUTION Mo. Pac. Hosp</u> <u>1 HR.</u>		29 STREET ADDRESS <u>8mi. S OF DESOTO ON H.Y.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARION EDWARD HOGAN</u>		4. DATE OF DEATH Month Day Year <u>AUG. 13 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 19, 1906</u>
9. AGE (In years last birthday) <u>52</u>		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) <u>CARMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MO. PAC. SHOPS</u>	11. BIRTHPLACE (City and state or country) <u>VAN BUREN - ARK.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>WILLIAM HOGAN</u>	
14. MOTHER'S MAIDEN NAME <u>FRANCES STONE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>489-10-6271</u>		17. INFORMANT Address <u>LUCILLE HOGAN DeSoto RT. #3</u>	
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) _____ DUE TO (c) _____ CONDITIONAL IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (b) OR (c) (Give 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>420.1</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
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.) <u>420.1</u>		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>8-13-58</u> to <u>8-13-58</u> and last saw him alive on <u>8-13-58</u> Death occurred at <u>11 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>(Mrs. E. Fallett md)</u>		22b. ADDRESS <u>De Soto Mo.</u>	
22c. DATE SIGNED <u>8-14-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	
23b. DATE <u>AUG. 17, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PRIMROSE CEM.</u>	
23d. LOCATION (City, town, or county) <u>DESOTO RT.</u>		(State) <u>Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>D. B. DIETRICH De Soto Mo</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 19 58</u>	
26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, md</u>			

(Licensed Embalmer's Statement on Reverse Side)

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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.....  
*[Handwritten Signature]*

Licensed Embalmer No. 4410.

P. O. Address.....  
*[Handwritten Address]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.