

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025192

FILED VS AUG 14 1959

3646

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3646

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before of admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City	Length of stay in 1b 5 yrs.	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) HOSPITAL OR INSTITUTION K.C.T.B. Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 708 Garfield
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First MARTIN Middle JOHN Last HOGAN			4. DATE OF DEATH Month 7 Day 24 Year 1959			
---	--	--	---	--	--	--

5. SEX Male	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 7-4-98	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-----------------------	----------------------------------	---	-----------------------------------	-------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook	10b. KIND OF BUSINESS OR INDUSTRY Restaurants	11. BIRTHPLACE (City and state or country) Youngstown, Ohio	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	---	---	--

13a. FATHER'S NAME Patrick J. Hogan	13b. MOTHER'S MAIDEN NAME Dorothy Ann Harrison	14. NAME OF HUSBAND OR WIFE Dale Eloise Shotts Hogan
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. "unknown"	17. INFORMANT Address K.C., Mo/ Mrs. Louise Pierce: 2037 1/2 Blue Ridge
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____, 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 7-24-59 9:30am to 7-24-59 and last saw her/him alive on 7-24-59 Death occurred at 8:51 P on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>Edward P. Altomare M.D.</i>	22b. ADDRESS <i>Kansas City Tubercular Hosp.</i>	22c. DATE SIGNED <i>7-28-59</i>
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Anatomical	23b. DATE 7-29-59	23c. NAME OF CEMETERY OR CREMATORY University of K.C. School of Dentistry	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
--	-----------------------------	---	---

24. FUNERAL DIRECTOR WEILERT FUNERAL HOMES (S) K.C., MO.	25. DATE RECD. BY LOCAL REG. 7-28-59	26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>
--	--	---

DOCUMENT

BY AFFIDAVIT OF Edward P. Altomare M.D. MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed A. E. Weelant

Licensed Embalmer No. 4075

P. O. Address K.C. 8. W.

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.