

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS JAN - 8 1960

211949

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Crawford | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b | c. CITY OR TOWN Cherryville |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Glennon Memorial Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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|--|----------------------------------|---|--|---|--|
| 3. NAME OF DECEASED (Type or print) First Penelope Middle Anne Last Hogan | | | 4. DATE OF DEATH Month December Day 20 Year 1959 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3/31/1959 | 9. AGE (last birthday) IF UNDER 1 YEAR Months 8 Days 20 | IF UNDER 24 HR Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | |
| 10c. CITIZEN OF WHAT COUNTRY U.S. | | | | | |

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|--|--|---|--|---|--|
| 13a. FATHER'S NAME Harry Hogan | | 13b. MOTHER'S MAIDEN NAME Virginia Harmon | | 14. NAME OF HUSBAND OR WIFE None | |
| 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 Harry Hogan, Cherryville, Mo. | |

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|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia bilateral acute | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Car Pulmonale | | | |
| DUE TO (c) Possible Congenital Malfunctions of Lungs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 759.0 | | | 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 checked="" 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.) 759.0 | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | 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 **Sept 1, 1959** to **Dec 20, 1959** and last saw her alive on **Dec 20, 1959**
Death occurred at **10:40 pm on Dec 20, 1959** on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | | |
|--|------------------------------|---|---|-------------------------------------|
| 22a. SIGNATURE (Degree or title) Richard A. Loney md | | 22b. ADDRESS Glennon Memorial | | 22c. DATE SIGNED 12-24-59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 12-23-59 | 23c. NAME OF CEMETERY OR CREMATORY Sellers Cemetery | 23d. LOCATION (City, town, or county) (State) Davisville, Mo. | |
| 24. FUNERAL DIRECTOR Jonas Funeral Home, Steelville, Mo. | | 25. DATE RECD. BY LOCAL REG. DEC 24 1959 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 

Licensed Embalmer No. 4108

P. O. Address Haines

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.