

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS DEC 23 1959

'59 0 4 5 5 6 5

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **211479**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Williamson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN Marion
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1406 North Logan
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Irma Middle (None) Last Hogg			4. DATE OF DEATH Month Dec. Day 10 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-20-1903	9. AGE (last birthday) 56	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) Bellknapp, Ill.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME C. O. Kean		13b. MOTHER'S MAIDEN NAME Allie Fisher		14. NAME OF HUSBAND OR WIFE J. W. Hogg Marion, Ill.	
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. John Withers Hogg) J. W. Hogg, Marion, Ill.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Pulmonary Embolus and Myocardial Infarction			
DUE TO (b) Cerebro-vascular Thrombosis - PE			2 weeks
DUE TO (c) Hypertensive cardiac-vascular disease			Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes mellitus			PART III. If deceased was pregnant in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) 443x	
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 **12-9-59** to **12-10-59** and last saw her/him alive on **12-9-59**
 Death occurred at **5:15 Am** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE George E. Rouillon		(Degree or title) MD		22b. ADDRESS 3720 Washington Ave St. L.	22c. DATE SIGNED 12-10-59
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-13-59	23b. DATE 12-13-59	23c. NAME OF CEMETERY OR CREMATORY Anderson Cemetery		23d. LOCATION (City, town, or county) (State) Massac County, Ill.	
24. FUNERAL DIRECTOR J. J. Kassly Funeral Home		ADDRESS E. St. Louis, Ill.		25. DATE RECD. BY LOCAL REG. DEC 11 1959	26. REGISTRAR'S SIGNATURE Loard Smith, M.D.

G. E. 711

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 Not Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Joseph G. Kowalsky
Licensed Embalmer No. _____

P. O. Address _____

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.