

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED AS JAN - 4 1960

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STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3446

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1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood		Length of stay in 1b 11 days		c. CITY OR TOWN Kirkwood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 340 W. Argonne Drive			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle J. Last HOGAN				4. DATE OF DEATH Month December Day 24 Year 1959			
5. SEX Male	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 8/15/83	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY R.R. Tire Manufacture		11. BIRTHPLACE (City and state or country) Altamont, Ill		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Michael E. Hogan			13b. MOTHER'S MAIDEN NAME Louy Dial		14. NAME OF HUSBAND OR WIFE Loretto Hogan		
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 Mrs. Loretto Hogan, 340 W. Argonne, Kirkwood, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA							INTERVAL BETWEEN ONSET AND DEATH 10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. HEART DISEASE Pulmonary Emphysema							10 yrs
DUE TO (c) BRONCHIAL ASTHMA							15 yrs
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, state a pregnancy in last 50 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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.)					
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 Jan. 1958 to Dec 24 1959 and last saw him alive on Dec 23, 1959 Death occurred at 8:10 AM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Lee W. Hankner MD				22b. ADDRESS 950 Francis Pl. Clayton 5 Mo.		22c. DATE SIGNED 12/24/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/28/59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.			
24. FUNERAL DIRECTOR Louis H. Bopp Inc			ADDRESS Kirkwood Mo	25. DATE RECD. BY LOCAL REG. 12-25-59	26. REGISTRAR'S SIGNATURE John C. Murphy MD		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 23 1960

_____ of this certificate was embalmed by m
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Thomas J. Myland Jr
Licensed Embalmer No. 4517
P. O. Address Winwood,

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