JRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

sic fan FILED VS FEB 1 0 1960

-60-008362

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 883

ENDED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b

c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) DePaul Hospital — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 6111 Magnolia Ave. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First GEORGE Middle Last HOGG

4. DATE OF DEATH Month Jan. Day 25 Year 1960

5. SEX Male

6. COLOR OR RACE White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 7-23-1882

9. AGE (last birthday) 77

IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec'y.-Treas. Buckley

10b. KIND OF BUSINESS OR INDUSTRY Shirt Co.

11. BIRTHPLACE (City and state or country) New Baden, Ill.

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Unknown Hogg

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Late Anna Hogg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO.

17. INFORMANT Robert Hogg Address 1219 Drayton W.G.,Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Obstructive Jaundice ~~Cirrhosis of Liver~~
INTERVAL BETWEEN ONSET AND DEATH 2 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cystic Carcinoma of Pancreas
DUE TO (c) 157 x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ~~Abdominal Aortic Aneurysm~~

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 1952, to 1-25-60 and last saw ~~her~~ him alive on 1-24-60
Death occurred at 9:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H.O. Schrepel, M.D.

22b. ADDRESS 634 No. Grand, St. Louis, Mo

22c. DATE SIGNED 1-25-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE Jan.28,1960

23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery

23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.

24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 S.Kingshighway

25. DATE RECD. BY LOCAL REG. JAN 25 1960

26. REGISTRAR'S SIGNATURE Earl Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

B Cystic Carcinoma of Pancreas
part 11 Abdominal Aortic Aneurysm
BY AFFIDAVIT OF DOCUMENT

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_____ Signed William B White

Signature of Student Embalmer

Licensed Embalmer No. 4291

P. O. Address 4228 Sterling

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