

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014187

FILED VS MAY 9 1960

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Primary Registration District No. 3006

Registrar's No. 259

STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <i>Boone</i>	Length of stay in 1b	a. STATE <i>Missouri</i>	b. COUNTY <i>Pettis</i>
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <i>Columbia MO</i>	<i>2 day</i>	c. CITY OR TOWN <i>Sedalia</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Univ. of Mo. med. center</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>1004 N. Osage St.</i>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <i>Walker</i>	Middle <i>Wesley</i>	Last <i>Hogan</i>	4. DATE OF DEATH	Month <i>4</i>	Day <i>29</i>	Year <i>60</i>
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>5-6-37</i>	9. AGE (last birthday) <i>22</i>	IF UNDER 1 YEAR	IF UNDER 24 HR
					Months	Days
					Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Packing Co.</i>	11. BIRTHPLACE (City and state or country) <i>Otterville, Mo.</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Walker W. Hogan</i>	13b. MOTHER'S MAIDEN NAME <i>Hattie Bush</i>	14. NAME OF HUSBAND OR WIFE <i>None</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Yes 6/10/55-10/7/57</i>	16. SOCIAL SECURITY NO. <i>499-38-9348</i>	17. INFORMANT <i>Mrs. Ruth V. Morney</i>	Address <i>Otterville, Mo.</i>
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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:	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Anoxia</i>	<i>2 hrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) <i>atelectasis</i>	<i>2 hrs</i>
DUE TO (c) <i>Bronchopneumonia</i>	<i>2 d</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Fracture of 5th cervical vertebra with spinal cord damage</i>	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
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from *4-27-60*, to *4-29-60* and last saw her/him alive on *4-29-60*
Death occurred at *10:30 PM 4-29-60* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>John H. Legans M.D.</i>	(Degree or title)	22b. ADDRESS <i>Univ. of Mo. med. center</i>	22c. DATE SIGNED <i>4/29/60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>5/8/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Crown Hill Cemetery</i>	23d. LOCATION (City, town, or county) <i>Sedalia Mo.</i>
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24. FUNERAL DIRECTOR <i>Luice Berg...</i>	ADDRESS <i>400 W. Cooper St.</i>	25. DATE RECD. BY LOCAL REG. <i>May 2 1960</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. R.E. Palmer</i>
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Sedalia Mo (Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 10 1960

JUN 3 1960

MAY 9 1960

MAY 10 1960

STATEMENT BY LICENSED EMBALMER

MAY 13 1960

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 W. C. Adams

Licensed Embalmer No. 4242

P. O. Address Suburban

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.