

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-013779  
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1600

**FILED APR 17 1961**

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>33 years</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1101 Main St.</b>		d. STREET ADDRESS (if outside, give location) <b>1229 Romany Rd.</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Edwin C. Hogueland</b>	4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>1961</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 4, 1908</b>	9. AGE (last birthday) <b>52</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice President - Harzfeld's</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Hutchinson, Kansas</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Ernest Hogueland</b>	13b. MOTHER'S MAIDEN NAME <b>Laura Etta Foulke</b>	14. NAME OF HUSBAND OR WIFE <b>Ruth Hogueland</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Ruth Hogueland, 1229 Romany Rd. K. C., Mo.</b>
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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) <b>Crushed skull + chest</b> <b>fractured limbs + arms</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Alcohol + Impairment</b>	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 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.) <b>Rumped or fell from a</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <b>3-28-61</b>	20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) <b>Store</b>	20f. CITY, TOWN, OR LOCATION <b>Kansas City</b>	COUNTY <b>Jackson</b>	STATE <b>Mo</b>
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21. I attended the deceased from _____, to _____ and last saw _____ alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Hugh H Owens Corner</b>	22b. ADDRESS <b>152 Union Station</b>	22c. DATE SIGNED <b>3-30-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-30-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah</b>	23d. LOCATION (City, town, or county) <b>Kansas City, Missouri</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Stine &amp; McClure, Kansas City, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-30-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 ITEM NO. SHOULD READ  
 BY AFFIDAVIT OF  
 OWNERS  
 MEDICAL CERTIFICATION  
 DOCUMENT  
 INSTEAD 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 William M. Turner

Licensed Embalmer No. 4648

P. O. Address Kansas City

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.