

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028361

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

38

Primary Registration District No. 3006

Registrar's No. 500

STATE FILE NUMBER

AMENDED

Registration District No.

FILED AUG 21 1961

1. PLACE OF DEATH a. COUNTY <b>Boone</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cole</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Columbia</b>		Length of stay in 1b <b>2 days</b>	c. CITY OR TOWN <b>Russellville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Medical Center MU</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Ethrage Hale Hogg</b>			4. DATE OF DEATH Month Day Year <b>8 11 1961</b>		
5. SEX <b>Female</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>2-20-99</b>	9. AGE (last birthday) <b>62</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>MO, Cole county</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Jim Hale</b>		13b. MOTHER'S MAIDEN NAME <b>Alice Vaughn</b>		14. NAME OF HUSBAND OR WIFE <b>Arthur Hogg</b>	
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 <b>Medical Center, Hospital Records</b> Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **RESPIRATORY FAILURE**

CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) **CHRONIC EXTRINSIC + INTRINSIC ASTHMA 52 yrs.**

DUE TO (c) \_\_\_\_\_

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 was there a pregnancy in last 90 days.  
 Yes  No  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 a.m. 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 **AUG. 9, 1961** to **AUG. 11, 1961** and last saw him alive on **AUG. 11, 1961**  
Death occurred at **3:25 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (degree or title) <b>Monis Linder M.D.</b>		22b. ADDRESS <b>New Hope Columbia, Mo</b>		22c. DATE SIGNED <b>8/11/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-14-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Russellville, Mo</b>		23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR <b>Lynnan Jankle, Columbia, Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Aug 12, 1961</b>	26. REGISTRAR'S SIGNATURE <b>Mrs R.E. Palmer</b>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 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,  
by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lynwood H. Spunkle

Licensed Embalmer No. 4013

P. O. Address Columbia

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.