ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

4992 - 61 - 036963
STATE FILE NUMBER

AMENDED

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

FILED OCT 19 1961

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City, — Length of stay in 1b 40 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Kings Nursing Home — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 2413½ Troost Avenue — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Earl — Middle Richard — Last Hogan
4. DATE OF DEATH: Month 10 — Day 3 — Year 61
5. SEX: male
6. COLOR OR RACE: Negro
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11-25-92
9. AGE (last birthday): 68 — 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): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Plumbing
11. BIRTHPLACE (City and state or country): Otterville, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Jim Hogan
13b. MOTHER'S MAIDEN NAME: Emma Lyles
14. NAME OF HUSBAND OR WIFE: Josephine Hogan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes — (If yes, give war or dates of service) WW # 1
16. SOCIAL SECURITY NO.:
17. INFORMANT: Josephine Hogan, Address K. C. 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) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive Cardiovascular Disease
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 ☐ 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 9/29/61, to 10/3/61 and last saw him alive on 10/3/61
Death occurred at ? 4:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE George H. Taft, M.D. (Degree or title)
22b. ADDRESS 2204 E. 18th Street
22c. DATE SIGNED 10/6/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremoval
23b. DATE 10-9-1961
23c. NAME OF CEMETERY OR CREMATORY National Cemetery
23d. LOCATION (City, town, or county) (State) Fort Leavenworth, Kansas
24. FUNERAL DIRECTOR Mrs. Meek's Mortuary, K. C. Mo. — ADDRESS
25. DATE RECD. BY LOCAL REG. 10-7-61
26. REGISTRAR'S SIGNATURE Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF George H. Taft — DOCUMENT — INSTEAD OF — SHOULD READ — DATE AMENDED — ITEM NO.

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 Millard B. Pasku

Licensed Embalmer No. 5013

P. O. Address K.C. MO

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.