

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **9894**

Registration District No. **1**

Primary Registration District No. **1**

Registrar's No. **109**

**1. PLACE OF DEATH:**  
(a) County **Adair**  
(b) City or town **Kirksville**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**1615 South Beard St.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community **500yr.** years, months or days)

**3. (a) PRINT FULL NAME** **Sarah Ellen Hogue**  
**3. (b) If veteran, name war** **none** **3. (c) Social Security No.** **none**

**4. Sex** **female** **5. Color or race** **white** **6. (a) Single, widowed, married, divorced, widowed**  
**6. (b) Name of husband or wife** **Nathaniel Hogue** **6. (c) Age of husband or wife if alive** \_\_\_\_\_ years  
**7. Birth date of deceased** **Aug. 21 1857**  
(Month) (Day) (Year)

**8. AGE:** **83** Years **84** Months **7** Days **17** If less than one day  
hr. min.

**9. Birthplace** **Chariton Co. Missouri**  
(City, town, or county) (State or foreign country)

**10. Usual occupation** **At home**

**11. Industry or business**

**MOTHER** { **12. Name** **William Huckelby**  
**13. Birthplace** **Chariton Co. Missouri**  
(City, town, or county) (State or foreign country)  
**14. Maiden name** **Louanna Vincent**  
**15. Birthplace** **Chariton Co. Missouri**  
(City, town, or county) (State or foreign country)

**16. (a) Informant** **Louanna Vincent**  
**(b) Address** **Kirksville Mo.**

**17. (a)** **burial** **(b) Date thereof** **4-9-1941**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** **Hogue Cent.**

**18. (a) Signature of funeral director** **Laura Riley**  
**(b) Address** **Kirksville Mo.**

**19. (a)** **April 9/41** **(b)** **Spencer L. Freeman**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Missouri** (b) County **Adair**  
(c) City or town **Kirksville**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1615 South Beard St.**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **April** day **7th.**  
year **1941** hour **11:30** minute **A** M.

**21. I hereby certify that I attended the deceased from** **March 25**  
**1941** to **April 7** **1941**  
that I last saw **her** alive on **March 7** **1941**  
and that death occurred on the date and hour stated above.

Immediate cause of death **bronchial pneumonia**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions **DM**  
(Include pregnancy within 3 months of death)

**Major findings:**  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

**22. If death was due to external causes, fill in the following:**

**(a) Accident, suicide, or homicide (specify)** \_\_\_\_\_  
**(b) Date of occurrence** \_\_\_\_\_  
**(c) Where did injury occur?** \_\_\_\_\_ (City or town) (County) (State)  
**(d) Did injury occur in or about home, on farm, in industrial place, in public place?** \_\_\_\_\_

**23. Signature** **J. B. Ramsey** **(M. D. or other)** **D**  
**Address** **Kirksville Mo.** **Date signed** **4-9-41**  
While at work? **3** (Specify type of place) (b) Means of injury \_\_\_\_\_

**Duration**  
**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**RECEIVED**

Sanitary Health Officer No. 10

File Number 4-41-827

Date Filed APR 14 1941

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Laura Riley

Licensed Embalmer No. 3907

P. O. Address Kirksville Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

2  
-41  
-39  
K28390

Registration District No. 1

Primary Registration District No. 1

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirkville Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Sarah Ellen Hogue

3. (b) If veteran, name war: \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband on date of death \_\_\_\_\_  
years

7. Birth date of deceased Aug-21-1857  
(Month) (Day) (Year)

8. AGE: Years 83 Months 7 Days \_\_\_\_\_  
Unless than one day

\_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) June 9/41 (b) Spencer L. Freeman  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 7  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature L. B. Farrington (M. D. or other) \_\_\_\_\_

Address Kirkville Mo Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

S-9894 1941

---

---

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**