

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34967**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9136**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		a. STATE Illinois	b. COUNTY Greene
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) Carrollton	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital		d. STREET ADDRESS (If rural, give location) W.R.	

3. NAME OF DECEASED (Type or Print)	a. (First) John	b. (Middle)	c. (Last) Brogan	4. DATE OF DEATH (Month) (Day) (Year)
				Oct. 23, 1949

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 12, 1870	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Marshall, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.		

13a. FATHER'S NAME Jerome Brogan	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Ruth Brogan
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Ralph Brogan	ADDRESS 4531a Elmbank
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 3 days
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b) Lympho-sarcoma with metastasis to brain		6 mo
DUE TO (c) Metastasis to brain		6 mo	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 1987

22. I hereby certify that I attended the deceased from **June 19, 1942**, to **Oct 23, 1949**, that I last saw the deceased alive on **Oct 23, 1949**, and that death occurred at **4:45a m.**, from the causes and on the date stated above.

23a. SIGNATURE J. A. Foster (Degree or title)	23b. ADDRESS 4937 Maple St. E.	23c. DATE SIGNED 10/24/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 10-23-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Carrollton, Ill.
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DATE REC'D BY LOCAL REG. OCT 24 1949	REGISTRAR'S SIGNATURE J. A. Foster	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Guy W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address St. Louis 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 this body is not embalmed, fact should be so stated above.