

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1940

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

9380  
Do not use this space.

**1. PLACE OF DEATH**

(a) County..... Registration District No. **791**  
 (b) Township..... Primary Registration District No. **1003** Registered No. **2863**  
 (c) City **ST. LOUIS MO** (d) Street No. **ST. LUKE'S HOSPITAL** St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

**2. PRINT FULL NAME** ROBERT L. HOXIE

(a) Residence, No. RT. #1 St. **NR** CHESTERFIELD, MO.  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **MALE** 4. COLOR OR RACE **WHITE** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED **MARRIED**  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **HELEN HOXIE**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **JAN 29 1904**

7. AGE YEARS **36.** MONTHS **1.** DAYS **28** If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. **BROKER.**  
 10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **MO.**

FATHER 13. NAME **ROBERT S. HOXIE**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **NY.**

MOTHER 15. MAIDEN NAME **ALICE MAY HOXIE**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **GA.**

17. INFORMANT Mrs Helen Hoxie  
 (ADDRESS) RT #1 CHESTERFIELD MO.

18. BURIAL, CREMATION, OR REMOVAL PLACE BELLEFONTAIN DATE MARCH 28 1940

19. FUNERAL DIRECTOR (NAME) F. M. Mullin  
 (ADDRESS) 5165 DELMAR BLD.

20. FILING DATE 2-7-1940

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **3-27 1940**

22. I HEREBY CERTIFY, That I attended deceased from **3-24 1940** to **3-27 1940**

I last saw him alive on **3-27 1940** Death is said to have occurred on the date stated above, at **4 P.M.**

The principal cause of death and related causes of importance were as follows:

*Acute dilatation of heart with hemorrhagic congestion of internal organs.*

Date of onset

Other contributory causes of importance: *Summary of Beans (Maligant)*

Name of operation *None* Date of.....

What test confirmed diagnosis?..... Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?..... If so, specify.....

(Signed) *X. M. McNamee*, M. D.

(Address) *4952 Maryland Ave.*

**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 John Kethers

Licensed Embalmer No. 3880

P. O. Address.....

**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, above space should be left blank.**