

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

1941

District No. 720

Primary Registration District No. 5957

State File No.

Registrar's No. 11

1. PLACE OF DEATH: Putnam
 (a) County Putnam
 (b) City or town Liberty, Rural, Thom
 (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 SAMUEL JACKSON HOSKIN
 3. (b) If veteran, name war U
 3. (c) Social Security No. L

4. Sex M - O 5. Color or race
 6. (a) Single, widowed, married, divorced M -
 6. (b) Name of husband or wife
 6. (c) Age of husband or wife if alive 60 years
 7. Birth date of deceased May 7 1877
 (Month) (Day) (Year)

8. AGE: Years 64 Months 1 Days 2 If less than one day
 hr. min.

9. Birthplace Mo In
 (City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business

MOTHER FATHER
 12. Name Lewis Hoskin
 13. Birthplace Ohio 1
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Kurts
 15. Birthplace Ohio 1
 (City, town, or county) (State or foreign country)

16. (a) Informant Clark Hoskin
 (b) Address Luronia, Mo

17. (a) Burial (b) Date thereof 6-11-41
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Concord

18. (a) Signature of funeral director Ernest Ryon

(b) Address Luronia, Mo

19. (a) July 23-41 G. E. McCallister
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Putnam 86
 (c) City or town Luronia, Mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. Luronia, Mo
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 9
 year 41 hour 8 minute P.M.
 21. I hereby certify that I attended the deceased from 5th month
 1941 to 6-9 1941
 that I last saw him alive on 6-8 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death
 Cerebral Hemorrhage
 Duration
 Due to
 Due to 830
 Other conditions
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations
 Of autopsy
 Underline the cause to which death should be charged statistically.

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 P. V. West (M. D. or other) D
 Address Luronia, Mo Date signed 6/10

RECEIVED

District Health Officer No. 10

District File Number 8-41-1433

Date Filed AUG 6 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 M. E. Husted

Licensed Embalmer No. 3304

P. O. Address Unionville

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.

STANDARD CERTIFICATE OF DEATH

State File No. 25931

Registration District No. 720

Primary Registration District No. 2957

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Putnam
(b) City or town Liberty Rural
(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

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 _____

3. (a) PRINT FULL NAME Samuel J. Haskin

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) Aug-1-46 E.E. McCallister
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I first saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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SUPPLEMENTARY

