

FILED SEP 12 1941
399

Registration District No. _____

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether years, months or days) 14 years 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 049
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1215 Troost Avenue
(If rural, give location)
(e) Citizen of foreign country? American (Yes or No)
If yes, name country 17

3. (a) PRINT FULL NAME

WILLIAM HOSKINS

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Male^D 5. Color or race wh 6. (a) Single, widowed, married divorced Married
6. (b) Name of husband or wife Mrs. Anna Hoskins 6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased Aug. 13 1873 (Month) (Day) (Year)

8. AGE: Years 68 Months 0 Days 9 days hr. min.

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

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER { 12. Name Thos Hoskins
13. Birthplace Ky.
14. Maiden name Elizabeth C. as first
15. Birthplace Ky.

16. (a) Informant M. M. Robinson
(b) Address Rural

17. (a) (Burial, cremation, or removal) (b) Date thereof 8/25/41 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn Cem

18. (a) Signature of funeral director J. C. 720
(b) Address

19. (a) (Date received local registrar) 8/25/41 (b) M. M. Robinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 22nd
year 1941 hour 2 minute 10 P. M.

21. I hereby certify that I attended the deceased from 8-18-41 to 8-22-41, 1941, and that I last saw him alive on 8-22-41, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary sclerosis, cardiac hypertrophy, pulmonary thrombosis left

Due to 95%

Other conditions: (Include pregnancy within 6 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?

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

23. Signature D. D. R. Thoen (M. D. or other) Med. Dir. K.C. Gen. Hospital 8-23-41 Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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.....

Chas. W. Ware

Licensed Embalmer No.....

2570

P. O. Address.....

918 Brooklyn

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.