S. No. 3

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 21 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14729

Registration District No. 448449 Primary Registration District No. 4267 Registrar's No.

53
1
2

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

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon Twp
(If outside city or town limits, write "RURAL," and name of township)
(c) Name of hospital or institution: Wallace Memorial D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 3 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede 53
(c) City or town Lebanon 1
(If outside city or town limits, write "RURAL")
(d) Street No. 216 N Madison 2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME George HOSKINS
3. (b) If veteran, name war ✓
3. (c) Social Security No. 346-14-3492
4. Sex Male D
5. Color or race White
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 1889 (Month) (Day) (Year)

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

9. Birthplace Don't Know (City, town, or county) U (State or foreign country)
10. Usual occupation Plaster
11. Industry or business
FATHER 12. Name Don't Know
13. Birthplace Don't Know (City, town, or county) U (State or foreign country)
MOTHER 14. Maiden name Don't Know
15. Birthplace Don't Know (City, town, or county) U (State or foreign country)
16. (a) Informant Wallace Hospital Staff
(b) Address Lebanon
17. (a) removal (Burial, cremation, or removal) (b) Date thereof April 28 1942 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director W. E. Holman
(b) Address Lebanon
19. (a) April 28-42 (Date received local registrar) (b) Grace Roper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27 year 1942 hour 7 minute 30 P.M.
21. I hereby certify that I attended the deceased from Apr. 27, 1942 to Apr. 27, 1942 that I last saw him alive on Apr. 27, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hemmorhage of Stomach	1
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) acute nephritis	C

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)
(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 D
23. Signature [illegible] (M. D. or other)
Address Lebanon Mo Date signed 4-28-42

1070 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
MAY 30 1940

District Health Officer No.
District File Number 5-42 83
Date Filed May 15, 1940

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 Dorsey M. Haine

Licensed Embalmer No. 4222

P. O. Address Lebanon, 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.

V. S. No. 2B
10M--8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14729

Registration District No. 449 Primary Registration District No. 4269 Registrar's No.

1. PLACE OF DEATH:
(a) County: Laclede
(b) City or town: Lebanon (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: — (Specify whether years, months or days)
In this community: —

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Laclede
(c) City or town: Lebanon (If outside city or town limits, write "RURAL")
(d) Street No.: 216 N. Madison (If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country: —

3. (a) PRINT FULL NAME: George Hoskins
3. (b) If veteran, name war: 1
3. (c) Social Security No.:
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced:
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: — (Month) — (Day) 1889 (Year)
8. AGE: Years 53 Months Days If less 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) (Burial, cremation, or removal) (b) Date thereof: (Month) (Day) (Year)
(c) Place: burial or cremation:
18. (a) Signature of funeral director:
(b) Address:
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. Day 27 year 1942 hour 7 minute 30 P.M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.
Immediate cause of death: Hemorrhage of stomach
Due to: Carcinoma of Stomach
Due to:
Other conditions: acute Nephritis (Include pregnancy within 3 months of death) due to chronic Nephritis
Major findings:
Of operations:
Of autopsy: Yes

Duration

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)
(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: J. Bummer (M. D. or other)
Address: Lebanon Mo. Date signed 6-13-42

SUPPLEMENTARY