

3. No. 7  
1-19-39  
17-39  
1-19-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

21855

State File No. \_\_\_\_\_

JUL 7 1943  
Registration District No. 178

Primary Registration District No. 4281

Registrar's No. 61

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Canton Canton  
(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 40 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis <sup>56</sup>  
(c) City or town Canton <sup>0</sup>  
(If outside city or town limit, write "RURAL")  
(d) Street No. 808 S 4th (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years <sup>0</sup>

3. (a) PRINT FULL NAME Almena Hoskins

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Fem. 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Henry Alexander Hoskins 6. (c) Age of husband or wife if 41 years  
7. Birth date of deceased Apr. 4 1876  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
67 2 11 hr. min.

9. Birthplace Adams County Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Housewife

11. Industry or business

MOTHER FATHER { 12. Name Daniel Ketchum  
18. Birthplace Unknown New York  
(City, town, or county) (State or foreign country)  
14. Maiden name BABYRITA ANN DARTY  
15. Birthplace Unknown Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Gus Bauer  
(b) Address Canton, Mo

17. (a) Burial (b) Date thereof June 17, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Paul's

18. (a) Signature of funeral director W. J. Buckley  
(b) Address Canton, Mo.

19. (a) 6/18/43 (b) P. W. Jennings  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15  
year 1943 hour 5 minute 30 A. M.

21. I hereby certify that I attended the deceased from June 1, 1943 to June 15, 1943  
that I last saw her alive on June 15, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute nephritis  2 wks.  
Duration

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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. W. Jennings (M. D. or other) MD  
Address Canton, Mo. Date signed 6/18/43

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

*Earl H. Buckley*

Licensed Embalmer No. *2615*

P. O. Address *Canton, 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, above space should be left blank.**

Registration District No. 178 Primary Registration District No. 4281

1. PLACE OF DEATH  
(a) County Jewett  
(b) City or town Casson  
(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 Almena Washburn  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ Year \_\_\_\_\_  
7. Birth date of deceased Apr 4 1917  
(Month) (Day) (Year)

8. AGE: Years 67 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace Ill.  
(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) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death acute nephritis Duration sub

Due to hypertension and  
preexisting chronic  
Due to nephritis

Other conditions (Include pregnancy within 5 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN 1318  
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) (c) Means of injury \_\_\_\_\_

23. Signature P. W. Jennings, M.D.

Address Casson Mo. Date signed 7/11/43

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

**SUPPLEMENTARY**

S-21855