

FILED JAN 20 1944

318

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1003

455

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

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 152

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Mo-Pac Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 month  
In this community 40 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 922 Chambers St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Esther Hoskins  
3. (b) If veteran, name war none  
3. (c) Social Security No. none

4. Sex female 5. Color or race white  
6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife late Albert Hoskins  
6. (c) Age of husband or wife if alive 12 years 1878  
7. Birth date of deceased: (Month) Oct. (Day) 12 (Year) \_\_\_\_\_

8. AGE: Years 65 Months 2 Days 22  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Ill.  
(City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

12. Name Unknown  
13. Birthplace Unknown  
(City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

16. (a) Informant Raymont Hoskins  
(b) Address 922 Chambers St.

17. (a) Burial (b) Date thereof 1-7-44  
(Burial, cremation, or removal) \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation Zion's Cemetery Hy. Leidner U. Co.

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address 2223 St. Louis Ave

19. (a) JAN 7 1944 (b) J. F. Bedeak  
(Date received local registrar) \_\_\_\_\_ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 4  
year 1944 hour 6 minute 50 P. M.  
21. I hereby certify that I attended the deceased from Jan 3  
\_\_\_\_\_ 19 44 to Jan 4 19 44  
that I last saw her alive on \_\_\_\_\_ 19 44  
and that death occurred on the date and hour stated above

Immediate cause of death: Acute congestive heart failure  
Arteriosclerotic heart disease

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) \_\_\_\_\_  
(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 J. F. Bedeak (M. D. or other) MD  
Address no one here Date signed 1-4-44

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

MOTHER FATHER

**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 Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address 2223 St. Louis ave

**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.**