V. S. No. 2
100M—5-43
Rev. 5-17-39
I X36571

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23087

FILED JUL 26 1944

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6349

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Pronounced dead at City Hospital (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: 000

(a) State MISSOURI (b) County 17

(c) City or town ST. LOUIS 920 (If outside city or town limits, write "RURAL")

(d) Street No. 2209 CASS AV. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Joseph O. HOBBINS.

3. (b) If veteran, name war NO.

3. (c) Social Security No.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, ~~widowed, married,~~ divorced SINGLE

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased DECEMBER (Month) 11. (Day) 1904 (Year)

8. AGE: Years 39 Months 7 Days 5 If less than one day hr. min.

9. Birthplace ST. LOUIS (City, town, or county) MO. 0 (State or foreign country)

10. Usual occupation CLERK MAIL.

11. Industry or business U. S. POST. OFFICE

FATHER
12. Name JOHN HOBBINS.
13. Birthplace MISSOURI 0 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name MARY GARIN.
15. Birthplace MISSOURI 0 (City, town, or county) (State or foreign country)

16. (a) Informant Mr John Hobbins

(b) Address 2209 Cass Av

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 19 44 (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director E. J. Schnur.

(b) Address 3125 Lafayette Av

19. (a) JUL 19 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 16 year 1944 hour 4 minute A M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid Hemorrhage of Brain when he was struck with the Fist of one Domenic Ricavali causing him to fall to the street around 4 am 7-16-44 In front of 1705 No Jefferson ave

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 168

Of autopsy

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) Accident

(b) Date of occurrence 7-16-44 000

(c) Where did injury occur? St Louis (City or town) (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place (Specify type of place)

While at work? No (e) Means of injury Fight

23. Signature Thomas F Callanan (M. D. or other)

Address Deputy Coroner Date signed 7-17-44

(Licensed Embalmer's Statement on Reverse Side)

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 Howard F Rowland

Licensed Embalmer No. 3114

P. O. Address St Louis 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.