V. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 16 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7139

Registration District No. 3175 Primary Registration District No. 6076 Registrar's No. 412

1. PLACE OF DEATH:
(a) County Saint Louis
(b) City or town Koch - Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 44 days (Specify whether
In this community 4 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County [illegible]
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 815 N. Jefferson Ave. 9
(If rural, give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country /

3. (a) PRINT FULL NAME WALTER PIERCE HOSKINS
3. (b) If veteran, name war
3. (c) Social Security No. 499-20-9795
4. Sex male
5. Color or race negro
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 3 (Month) 11 (Day) 1925 (Year)

8. AGE: Years 19 Months 10 Days 22 If less than one day hr. min.

9. Birthplace Caruthersville (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Joe Hoskins
13. Birthplace ? (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Brissie Gage
15. Birthplace (City, town, or county) Mississippi (State or foreign country)
16. (a) Informant Robert Koch Hospital record
(b) Address Koch - Mo
17. (a) Shipped (Burial, cremation, or removal) (b) Date thereof Feb. 10, 45 (Month) (Day) (Year)
(c) Place: burial or cremation Caruthersville Mo.
18. (a) Signature of funeral director Dement & Son
(b) Address 2629-31 Cole Street
19. (a) 2/10/45 (Date received local registrar) (b) E. G. McGauran (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 3 year 1945 hour 8 minute 15 P.M.
21. I hereby certify that I attended the deceased from 12-19, 1944, to 2-3, 1945; that I last saw him alive on 2-3, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Thoracoplasty	
Due to chronic Pulmonary Tuberculosis	15 m
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

13 F1

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 Bernard Friedman (M. D. or other) M D
Address Koch Hosp., Koch, Mo. Date signed 2-4-45

707 (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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.