

No. 2
-12-45
5-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22953
Registrar's No. 1416

FILED JUL 3 1947
Registration District No. 377

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Mount St. Rose Sanitorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days
(Specify whether years, months or days)

In this community 5 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME ALFRED FRANKLIN HOSTLER

3. (b) If veteran, name war nil

3. (c) Social Security No. 489-26-4953

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced D

6. (b) Name of husband or wife Ina

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

7. Birth date of deceased December 2, 1912
(Month) (Day) (Year)

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

34	6	26	hr. min.
----	---	----	----------

9. Birthplace Morehouse, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business _____

MOTHER FATHER

12. Name William Hostler

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Bertha Wilson

15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant William H. Hostler

(b) Address 34 Benton Place

17. (a) burial (b) Date thereof 7-1-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cem. J.B. MO.
A.W. McLaughlin

18. (a) Signature of funeral director _____

(b) Address 2301 Lafayette Av. St. Louis, Mo.

19. (a) 7-3-47 (b) Conrad J. Shapley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 34 Benton Place
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28th
year 1947 hour 3:00 minute PM

21. I hereby certify that I attended the deceased from 6-20-47, 19 to 6-28-47, 19
that I last saw him alive on 6-26-47, 19
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Chronic Pulm Tub

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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? 0

While at work _____ (Specify type of place)

(c) Means of injury _____

23. Signature Andrew C. Penick M.D.
(M.D. or other)

Address 607 N. Grand St. St. Louis Date signed 6/30/47

JUL 16 1947

JUL 16 1947

Dr. Andrew C. Henske
University Club Bldg.

PROCESSED BY STATE

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..... *P W Cooper*
Licensed Embalmer No. *3880*
P. O. Address *2301 Lafayette*

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.