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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED DEC 2 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1005

State File No. 38237
10208

Registrar's No.

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: U
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4019 Enright Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Steve Hobson

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced S U

6. (b) Name of husband or wife

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

7. Birth date of deceased October (Month) 6 (Day) 1870 (Year)

8. AGE: Years 78 Months 1 Days 15. If less than one day hr. min.

9. Birthplace Brandon (City, town, or county) Miss. (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Steve Hobson
13. Birthplace Brandon (City, town, or county) Miss. (State or foreign country)

MOTHER
14. Maiden name Hager McAfee
15. Birthplace Brandon (City, town, or county) Miss (State or foreign country)

16. (a) Informant Rosa Henderson
(b) Address 73 Wavely St. Buffalo, N.Y

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 (Month) 26 (Day) 1948 (Year)
(c) Place: burial or cremation Washington Park Cemetery

18. (a) Signature of funeral director J. H. Randle & Son
(b) Address 3133 Bell Ave

19. (a) NOV 2 6 1948 (Date received local registrar) (b) J. B. Lasater (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 21 year 1948 hour 10 minute 50 p M.

21. I hereby certify that I attended the deceased from Nov. 3, 1948, to Nov. 21, 1948, that I last saw him alive on Nov. 21, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
RENAL FAILURE WITH UREMIA; Diabetic Coma	Undet.
Due to	
Due to	
Other conditions Hypertrophy of Prostate (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy None

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 Silas O. Rivers (M. D. or other)
Address 2601 N Whittier Date signed 11/22/48

(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 S J Watson

Licensed Embalmer No. 269 S

P. O. Address 2769 Choutea

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.

No. 2B
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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. Dec

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10208

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

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

3. (a) PRINT FULL NAME Steve Hebron

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct 6 (Month) (Day) (Year)

8. AGE: Years 78 Months 1 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 12-6-48 (Date received local registrar) (b) J B Lasater (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 1 year 1948 hour minute 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 — Duration

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-38237