V.S. No. 300
EV. 10.48

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

FILED SEP 24 1949

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 31856

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7944

**1. PLACE OF DEATH**
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis,
c. LENGTH OF STAY (in this place): 23 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Barnes Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 4567 Forest Park

**3. NAME OF DECEASED** (Type or Print)
a. (First): BENJAMIN
b. (Middle): - - -
c. (Last): HOY.

**4. DATE OF DEATH** (Month) (Day) (Year): Sept. 12, 1949

**5. SEX**: male
**6. COLOR OR RACE**: white
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): married
**8. DATE OF BIRTH**: Aug. 29, 1909
**9. AGE** (In years last birthday): 40 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): salesman
**10b. KIND OF BUSINESS OR INDUSTRY**: Brown-Bigelow
**11. BIRTHPLACE** (State or foreign country): Marion, Illionis
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.
**13a. FATHER'S NAME**: Joseph Hoy
**13b. MOTHER'S MAIDEN NAME**: Maude Tate
**14. NAME OF HUSBAND OR WIFE**: Ruth Hoy
**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes, give war or dates of service)
**16. SOCIAL SECURITY NO.**:
**17. INFORMANT'S SIGNATURE OR NAME — ADDRESS**: Mrs. Ruth Hoy, 4567 Forest Park, St. Louis

**18. CAUSE OF DEATH** — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Liver Coma — INTERVAL BETWEEN ONSET AND DEATH: 36 Hours

ANTECEDENT CAUSES

*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Cirrhosis of liver — 15 Years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

*Conditions contributing to the death but not related to the disease or condition causing death.*

**19a. DATE OF OPERATION**: Aug. 30, 1949
**19b. MAJOR FINDINGS OF OPERATION**: Cirrhosis of liver
**20. AUTOPSY?** YES [X] NO [ ]

**21a. ACCIDENT / SUICIDE / HOMICIDE** (Specify):
**21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.):
**21c. (CITY, TOWN, OR TOWNSHIP)** (COUNTY) (STATE): 124 5
**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour) m.:
**21e. INJURY OCCURRED** WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
**21f. HOW DID INJURY OCCUR?**: 5810

22. *I hereby certify that I attended the deceased from* 8-20-49, 19____, *to* 9-12-49, 19____, *that I last saw the deceased alive on* 9-12-49, 19____, *and that death occurred at* 6:45 P.m., *from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): F.R. Bradley M.D.
**23b. ADDRESS**: Barnes Hospital
**23c. DATE SIGNED**: 9-12-49

**24a. BURIAL, CREMATION, REMOVAL** (Specify): removal
**24b. DATE**: 9-14-49
**24c. NAME OF CEMETERY OR CREMATORY**: Marion, Illinois
**24d. LOCATION** (City, town, or county) (State): Marion, Illinois

**DATE REC'D BY LOCAL REG.**: SEP 14 1949
**REGISTRAR'S SIGNATURE**: J B Lasater
**25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS**: C. R. Lupton & Sons, St. Louis, Mo.

(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 .....

..... Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed Arnold W. Schoene

Licensed Embalmer No. 3864

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.