

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11735**
2846

FILED MAR 31 1953

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

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | |
| c. LENGTH OF STAY (In this place) 15 yrs | | d. STREET ADDRESS (If rural, give location) 22 2827 Clark | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homér G Phillips Hospital | | e. DATE OF DEATH (Month) (Day) (Year) March 10 1953 | |

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|---|-------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Hoskins c. (Last) | | | 4. DATE OF DEATH (Month) (Day) (Year) March 10 1953 | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower | 8. DATE OF BIRTH Dec. 8, 1877 | | 9. AGE (In years last birthday) 75 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and State or Foreign Country) Grenada, Miss. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |

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|--|--|--|--|---|--|
| 13a. FATHER'S NAME Jack Hoskins | | 13b. MOTHER'S MAIDEN NAME unknown | | 14. NAME OF HUSBAND OR WIFE Callie | |
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|--|--|-------------------------|--|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Callie Brown 2827 Clark Ave. | |
|--|--|-------------------------|--|---|--|

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|--|--|---|--|--|----------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the splenic flexure of the large bowel | | II. OTHER SIGNIFICANT CONDITIONS None | | | |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | |
| | | DUE TO (b) _____ | | | |
| | | DUE TO (c) _____ | | | |

| | | | | | |
|------------------------|--|----------------------------------|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
|------------------------|--|----------------------------------|--|--|--|

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|--|--|--|--|---|--|
| 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) | |
|--|--|--|--|---|--|

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|---|--|--|--|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 153X | |
|---|--|--|--|--|--|

22. I hereby certify that I attended the deceased from **2-17, 1953, to 3-10, 1953**, that I last saw the deceased alive on **3-10, 1953**, and that death occurred at **4:55 a.m.**, from the causes and on the date stated above.

| | | | | | |
|--|--|--|--|---------------------------------|--|
| 23a. SIGNATURE Edwin E. Brooks, D. O. (Degree or title) | | 23b. ADDRESS 2601 N Whittier St | | 23c. DATE SIGNED 3-10-53 | |
|--|--|--|--|---------------------------------|--|

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|--|--|--------------------------|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 24b. DATE 3-16-53 | | 24c. NAME OF CEMETERY OR CREMATORY Greenwood | |
| | | | | 24d. LOCATION (City, town, or county) (State) St. Louis County, Mo | |

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|---|--|---|--|---|--|
| DATE REC'D BY LOCAL HEALTH DEPT. MAR 16 1953 | | REGISTRAR'S SIGNATURE J. Earl Smith md | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS DeMent & Son 2629-31 Cole St. | |
|---|--|---|--|---|--|

(Licensed Embalmer's Statement on Reverse Side)

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

LARGE BOWEL.

(MISS RHODES)

HOSPITAL CONTACTED.

CHOLESTEROL OF THE

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 H. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Alkin

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.