

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26487**
Registrar's No. **6087**

FILED JUL 31 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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, Missouri		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. John's Hospital		e. STREET ADDRESS (If rural, give location) 12 5086 Waterman Avenue.	

3. NAME OF DECEASED (Type or Print) a. (First) Ida b. (Middle) B. c. (Last) Hobbs	4. DATE OF DEATH (Month) (Day) (Year) June 17 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec 8 1872	9. AGE (In years last birthday) (Months) (Days) (Hours) (Mins.) 80	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Sharon, Tennessee	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) Sharon, Tennessee	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Hunt	13b. MOTHER'S MAIDEN NAME Unknown Beasley	14. NAME OF HUSBAND OR WIFE Louis Hobbs dec'd
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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. nil	17. INFORMANT'S SIGNATURE OR NAME Mrs. L.B. Lanier, 5086 Waterman Ave.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 8-10 yrs.
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Hypertension		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 332X
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22. I hereby certify that I attended the deceased from **11-15-1953**, to **6-17-1953**, that I last saw the deceased alive on **6-17-1953**, and that death occurred at **4:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Carl J. Smith, M.D.	(Degree or title)	23b. ADDRESS 188 Kingsborough	23c. DATE SIGNED 6-18-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-19-53	24c. NAME OF CEMETERY OR CREMATORY Kirbyton	24d. LOCATION (City, town, or county) (State) Kirbyton, Kentucky
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DATE REC'D BY LOCAL REG. JUN 18 1953	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, 4700 Washington	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed *John J. Haines*.....
Licensed Embalmer No. *4108*
P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.