

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27802**  
**6945**  
Registrar's No.

**FILED SEP 6 1955**

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 <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>		STREET ADDRESS (If rural, give location) <b>21 3071 Easton Avenue 2219</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Fred</b>		b. (Middle)		c. (Last) <b>Hoskins</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>8 7 55</b>		5. SEX <b>male</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>7-5-1900</b>		9. AGE (In years last birthday) <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Mississippi</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Steve Hoskins</b>		13b. MOTHER'S MAIDEN NAME <b>Robinson</b>	
14. NAME OF HUSBAND OR WIFE <b>Annie Hoskins 3306 Lucas</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>488 12 8843</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Annie Hoskins</b>		ADDRESS <b>3306 Lucas</b>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>Cerebral Hemorrhage</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <b>Cerebral Hemorrhage</b>		ANTECEDENT CAUSES <b>331x</b>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b>	
DUE TO (c) <b>Hypertensive Cardio-Vascular disease</b>		II. OTHER SIGNIFICANT CONDITIONS <b>with Cardiac Decompensation.</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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)	
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?		22. I hereby certify that I attended the deceased from <b>8-3-</b> , 19 <b>55</b> , to <b>8-7-</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>8-7-</b> , 19 <b>55</b> , and that death occurred at <b>11:20p.m.</b> , from the causes and on the date stated above.	

23a. SIGNATURE <b>Edw. B. Williams M.D.</b>		23b. ADDRESS <b>2601 N. Whittier Street</b>		23c. DATE SIGNED <b>8-8-55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		24b. DATE <b>8-10-1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks Mo.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		ADDRESS <b>216 So. Jeff.</b>	
DATE REC'D BY LOCAL REG. <b>AUG 9 1955</b>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	

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

S.P. (Licensed Embalmer's Statement on Reverse Side)

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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.....

Licensed Embalmer No. 26

P. O. Address 2769 d

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.