

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-020890

STATE FILE NUMBER

FILED JUN 23 1958

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 268

1. PLACE OF DEATH a. COUNTY <u>Boone County</u> <u>University of Mo. Med. Center</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Trenton, Mo.</u> b. COUNTY <u>Grundy</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Trenton</u> <u>04020</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Mo. Med. Center</u> <u>1 day</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>1819 Merrill</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>SHERRY</u> Middle <u>Lynne</u> Last <u>Hoskins.</u>			4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/9/45</u>	9. AGE (In years last birthday) <u>13 yrs.</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Billy T. Hoskins</u>	13b. MOTHER'S MAIDEN NAME <u>Ruth Hoskins</u>	14. NAME OF HUSBAND OR WIFE <u>—</u>
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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)	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>HOSPITAL RECORDS, Columbia, Mo</u> Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Collapse.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 yr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Congenital Heart Disease - Cyanotic</u>	
	DUE TO (c) <u>7545</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u>—</u> Month <u>—</u> Day <u>—</u> Year <u>—</u> a.m. <u>—</u> p.m. <u>—</u>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>—</u>	COUNTY <u>—</u>	STATE <u>—</u>
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21. I attended the deceased from Death occurred at <u>10:50</u> <u>6-18-58</u> to <u>6-19-58</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>6-19-58</u> A <u>—</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Gen Van Lennep MD</u> (Degree or title)	22b. ADDRESS <u>Univ Hosp, Columbia, Mo</u>	22c. DATE SIGNED <u>6-19-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6-19-1958</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <u>Trenton, Mo</u>
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24. FUNERAL DIRECTOR <u>Carver Funeral Service</u>	ADDRESS <u>Columbia, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>June 19, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>
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MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Kelly* .....  
Licensed Embalmer No. *4897* .....  
P. O. Address *Columbus, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.