

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-022608
STATE FILE NUMBER

FILED JUL 7 1958 Registration District No. 212 Primary Registration District No. 3044 Registrar's No. 40

5. 300
v. 1-57
MAR
1

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY MILLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY MILLER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Eldon		c. CITY OR TOWN Eldon	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 442 E. 3rd		Length of stay in 1b	
3. NAME OF DECEASED (Type or print) First CARRIE Middle BELLE Last HOSKINS		4. DATE OF DEATH Month JUNE Day 13 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 21, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Ashland, Mo.
13a. FATHER'S NAME SAMUEL J. CLAY		13b. MOTHER'S MAIDEN NAME ISABELL FOWLER	14. NAME OF HUSBAND OR WIFE SAMUEL M. Hoskins
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. NONE	17. INFORMANT CLAY Hoskins Address Eldon, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic myocardial degeneration Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive heart disease DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 443X
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.)	
20c. TIME OF INJURY Hour a.m. p.m.			
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 COUNTY STATE
21. I attended the deceased from 1955 to June 13, 1958 and last saw her June 5, 1958 alive on June 5, 1958 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Carl J. Butler Jr. M.D.		22b. ADDRESS Eldon Mo	22c. DATE SIGNED 6-16-58
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JUNE 15, 1958	23c. NAME OF CEMETERY OR CREMATORY Eldon	23d. LOCATION (City, town, or county) (State) Eldon, Mo.
24. FUNERAL DIRECTOR Louis D. Phillips ADDRESS Eldon		25. DATE RECD. BY LOCAL REG. June 16, 58	26. REGISTRAR'S SIGNATURE Adveretta Walt

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

JUN 24 '58

Miller County
Health Department

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 *Louis A. Phillips*

Licensed Embalmer No. *3663*

P. O. Address *Edwards*

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.