

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045825

STATE FILE NUMBER

12042

FILED DEC 24 1958

Registration District No. 318

318

Primary Registration District No. 1003

1003

Registrar

12042

300

1-57

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

| | | | | | | | |
|--|--------------------------------|---|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>E. St. Louis</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>St. Marys Infirmary</u> | | | Length of stay in lb <u>1 day</u> | d. STREET ADDRESS (If outside, give location) <u>1522 1/2 Colas Avenue</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MAUDE HOOSMAN</u> | | | | 4. DATE OF DEATH Month Day Year <u>December 11, 1958</u> | | | |
| 5. SEX <u>Fem</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>July 18, 1889</u> | | 9. AGE (In years last birthday) <u>69</u> | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Durant, Mississippi</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13a. FATHER'S NAME <u>Andrew Weems</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Vinie Clark</u> | | 14. NAME OF HUSBAND OR WIFE <u>Hubert Hoosman</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT <u>Hubert Hoosman, 1522 1/2 Colas, E. St. Louis</u> | | | Address <u>Ill</u> | |
| 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>CARCINOMA of THYROID GLAND</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>194X</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? <u>1 YES</u> <input type="checkbox"/> <u>NO</u> <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.) | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year 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 <u>July 4, 1958</u> to <u>DECEMBER</u> and last saw her <u>alive on 12/11/58</u> Death occurred at <u>11 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Frank P. Woodson, MD</u> | | | | 22b. ADDRESS <u>928 N. 2ND ST. E. ST. LOUIS, MO.</u> | | 22c. DATE SIGNED <u>12/13/58</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>12/15/58</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Garden of Memory</u> | | 23d. LOCATION (City, town, or county) (State) <u>Centerville, Illinois</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>R. M. C. Green, 4060 Washington Ave</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>DEC 15 '58</u> | | 26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>M&B.</u> | |

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 *Melvin E. Green*
Licensed Embalmer No. *4428*
P. O. Address *St. Louis, 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.