

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-045839

STATE FILE NUMBER 12110

FILED DEC 22 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY			
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>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
38 FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>In route City Hosp No I</u>		Length of stay in lb <u>1/27</u>		d. STREET ADDRESS (If outside, give location) <u>1015 Clarendon</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Earl Hull</u>				4. DATE OF DEATH Month Day Year <u>12-11-58</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 25, 1928</u>		9. AGE (In years last birthday) <u>30</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Labor Coatsop Ala'</u>		11. BIRTHPLACE (City and state or county) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
12. FATHER'S NAME <u>Robert Hull Sr</u>		13b. MOTHER'S MAIDEN NAME <u>Zelw Wallace</u>		14. NAME OF HUSBAND OR WIFE <u>Leoma Hull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>yes over II</u>		16. SOCIAL SECURITY NO. <u>421-32-1036</u>		17. INFORMANT Address <u>Leoma Hull 1015 Clarendon</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Internal Hemorrhage following gunshot IMMEDIATE CAUSE (a) <u>wound of the chest; suffered when shot with</u> <u>gun in the hands of one Harold Garner, in the</u> vicinity of <u>3418 Cook Ave., about 5:45 P.M.</u> Dec. 11th, 1958. WHETHER JUSTIFIABLE OR DUE TO (b) <u>HOMICIDAL COULD NOT BE DETERMINED.</u> DUE TO (c) <u>HOMICIDAL COULD NOT BE DETERMINED.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>E 981X</u>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>See Above</u>				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>St. Louis, Mo.</u>				
20d. INJURY OCCURRED WHILE AT WORK <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.) <u>On street</u>		21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>6<sup>24</sup></u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John In Jackson Deputy</u>		22b. ADDRESS <u>1300 Claib</u>		22c. DATE SIGNED <u>12/16/58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-18-58</u>		23c. NAME OR CEMETERY OR INTERMENT PLACE <u>National Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson Barrack Mo</u>	
24. FUNERAL DIRECTOR <u>A. H. Burk</u>		ADDRESS <u>3506 Franklin</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 16 58</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>m J B.</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Leroy M. Bannister* .....

Licensed Embalmer No. *4523* .....

P. O. Address *4257 Washington* .....

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.