

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011025  
STATE FILE NUMBER

XG-UNKNOWN

SI-18223

FILED MAR 18 1959

Registration District No.

Primary Registration District No.

Registration No.

1776

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN OVERLAND 423X	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 NO. GRAND		d. STREET ADDRESS 9111 E. MILTON	
3. NAME OF DECEASED (Type or print) First HARRIS Middle CHESTER H. HOSACK Last		4. DATE OF DEATH Month 2 Day 17 Year 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/38
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY	11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME LEONARD HOSACK	
13b. MOTHER'S MAIDEN NAME ELANORA FLOOD		14. NAME OF HUSBAND OR WIFE SINGLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, (or unknown) (If yes, give war or dates of service) YES ACTIVE DUTY PEACE TIME UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT VAH, 915 NO. GRAND AVE., ST. LOUIS, MO.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMACIATION DUE TO (b) FIBROSARCOMA OF BACK DUE TO (c) 197.1 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 1/2 MO.
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"/> NONE <input checked="" 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 WORK <input type="checkbox"/> 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 VA		COUNTY STATE	
21. I attended the deceased from 10/30/58 to 2/17/59 and last saw him alive on 2/17/59. Death occurred at 12:25 PM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE ROBERT K. YARE (Print name and title) Robert K. Yare M.D.		22b. ADDRESS VAH, ST. LOUIS, MO.	
22c. DATE SIGNED 2/17/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 2-20-1959	
23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY		23d. LOCATION (City, town, or county) (State) JEFFERSON BARRACKS, MO.	
24. FUNERAL DIRECTOR 2504 BAUMANN BROS. INC., OVERLAND, MO.		25. DATE RECD. BY LOCAL REG. FEB 19 '59	
26. REGISTRAR'S SIGNATURE Robert Smith, M.D.			

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 not embalmed, Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Pho. E. Huning .....

Licensed Embalmer No. ....  
P. O. Address .....

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.