URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-024616
STATE FILE NUMBER

FILED VS JUN 27 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5950

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. Louis
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION: 915 W. GRAND Veterans Hospital
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: ST. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3008 Easton
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Claude Middle: Hoskins Last: Jr.
4. DATE OF DEATH: Month: June Day: -8- Year: 1960
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Widowed ☐ Never Married ☒ Divorced ☐
8. DATE OF BIRTH: 9-23-37
9. AGE (last birthday): 22
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STudent
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (City and state or country): Caruthersville, Mo
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Claude Hoskins
13b. MOTHER'S MAIDEN NAME: Nettie Flowers
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): 1956 to 1958
16. SOCIAL SECURITY NO.:
17. INFORMANT: Claude Hoskins Address: 747 Bayard

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 331X
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 30 d, to and last saw her/him alive on
Death occurred at on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Joseph McGuire (Degree or Title) Coroner
22b. ADDRESS: 1300 Clark
22c. DATE SIGNED: 6-10-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): removal (motor)
23b. DATE: 6-13-60
23c. NAME OF CEMETERY OR CREMATORY: National
23d. LOCATION (City, town, or county) (State): J. B. Mo.
24. FUNERAL DIRECTOR: Dunn ADDRESS: 3847 Page
25. DATE RECD. BY LOCAL REG.: JUN 10 1960
26. REGISTRAR'S SIGNATURE: Noal Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Arthur L. Hellard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to con
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.