MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-000778

STATE FILE NUMBER

FILED VS JAN 31 1961 99

Registration District No. 99 Primary Registration District No. 41C-8 Registrar's No. 6

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY deKalb
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Maysville — Length of stay in 1b: life
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Sunset rest home — Inside Limits: Yes ☒ No ☐

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

3. NAME OF DECEASED (Type or print): First Edward Middle L Last Hoskins

4. DATE OF DEATH: Month 1-23-61 Day Year

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 2-3-1880

9. AGE (last birthday): 80 — 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): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (City and state or country): Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: W.C.Hoskins

13b. MOTHER'S MAIDEN NAME: Moriah Smith

14. NAME OF HUSBAND OR WIFE: Lula 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: John Hoskins Address: Fairport Mo.

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): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: few Minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Emphysema — years
DUE TO (c): Chronic Bronchitis

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 JAN 1960, to JAN 23, 1961 and last saw him alive on JAN 23, 1961
Death occurred at 11 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. Sweiger M.D.

22b. ADDRESS: Maysville, Mo

22c. DATE SIGNED: 1/26/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 1-25-61

23c. NAME OF CEMETERY OR CREMATORY: Smith

23d. LOCATION (City, town, or county) (State): Fairport Mo

24. FUNERAL DIRECTOR: John Brown — ADDRESS: Maysville Mo

25. DATE RECD. BY LOCAL REG.: Jan 24 1960

26. REGISTRAR'S SIGNATURE: [signature] Dep. Reg.

(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 me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed John B[illegible]

Signature of Student Embalmer

Licensed Embalmer No. 3933

P. O. Address Maysville 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.