SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11122 STATE FILE NUMBER 61-042535

FILED DEC 12 1961

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4347 Lafayette
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First | Middle | Last: Hoxsey
4. DATE OF DEATH Month, Day, Year: November 18, 1961

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11-15-61
9. AGE (last birthday)
IF UNDER 1 YEAR: Months | Days: 2
IF UNDER 24 HR: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY: United State

13a. FATHER'S NAME: Howard Gleyre Hoxsey
13b. MOTHER'S MAIDEN NAME: Dolores L. Hancock
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Dolores Hoxsey, Address: 4347 Lafayette, St. Louis, 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): Hemorrhagic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: less than 24 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Immaturity
DUE TO (c): Septicemia 763.5
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 11-15-61, to 11-18-61 and last saw him alive on 11-18-61
Death occurred at 4:45 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: P J Grant (Degree or title) M.D.
22b. ADDRESS: St. Louis Childrens Hospital
22c. DATE SIGNED: 11/21/61

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE: NOV 30 1961
23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: Rowland Mortuary Svc. ADDRESS: 4104-06 Manchester
25. DATE RECD. BY LOCAL REG.: NOV 30 1961
26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

ITEM NO. SHOULD READ INSTEAD OF DATE AMENDED DOCUMENT BY AFFIDAVIT OF

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_____

Signature of Student Embalmer

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.