MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County: Marion

Township: ~~Mason~~ or Village: or City: Hannibal (NO. 514 N. 3d St.; 1 Ward)

Registration District No.: 547 Primary Registration District No.: 3029

File No.: 14571 Registered No.: 125

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Abraham Hawkins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: March 22, 1872 (Month) (Day) (Year)

7 AGE: 47 yrs. — mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry business, or establishment in which employed (or employer): Pullman Co

9 BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS

10 NAME OF FATHER: Stephen Hawkins

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Not Known

12 MAIDEN NAME OF MOTHER: Hattie Hawkins

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Anna Ross.
(Address): Hannibal Mo.

15 Filed: April 16, 1919 Fenton B. Myers, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April 14th, 1919 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 2, 1919, to April 14, 1919, that I last saw he alive on April 14, 1919, and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:

(a) Nephritis - Insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. McMeekin M. D.

April 16, 1919 (Address) 217 Church

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Baker St. Cemt. DATE OF BURIAL: April 16, 1919

20 UNDERTAKER: Tom M. Smith. ADDRESS: Hannibal Mo.

MISSOURI STATE BOARD OF HEA
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Maria

Township Mari

or

Village

or

City Hamilton (NO. 517 N 33d St.; Ward)

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[If death occu hospital or in give its NAME of street and n

2 FULL NAME Frau Trust

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH ....., 1..... (Month) (Day) (Year)

7 AGE .....yrs.....mos.....ds. If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 14 ....., 191 (Month) (Day)

17 I HEREBY CERTIFY, that I attended decease Mar 2, 191 4, to Apr 14, 19 that I last saw h alive on Apr 14, 19 and that death occurred on the date stated above, at 9

The CAUSE OF DEATH* was as follows: Mitral Insufficien

(Duration).....yrs.....mos.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.

(Signed) W. M. Meeke

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Caus (1) Means of Injury; and (2) whether Accidental, Suicidal or Hom

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 1
20 UNDERTAKER	**ADDRESS**

T. A. SON, M. D., BONNE TERRE
EMMETT P. NORTH, M. D., ST. LOUIS
T. H. WILCOXEN, M. D., BOWLING GREEN
T. W. COTTON, M. D., VAN BUREN

W. A. CLARK, M. D., PRESIDENT, JEFFERSON CITY
W. J. FERGUSON, M. D., VICE-PRESIDENT, SEDALIA
GEO. H. JONES, M. D., SECRETARY, JEFFERSON CITY