24 1927

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

Do not use this space.
26565

1. PLACE OF DEATH

County Buchanan Registration District No. 85 File No.

Township Primary Registration District No. 1001 Registered No. 968

City St. Joseph, (No. Missouri Methodist Hospital St. Ward)

2. FULL NAME Verna Mae Hawkins,

(a) Residence. No. 2010 South 11th. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Married,

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF L. B. Hawkins-

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 19, 1896

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	31	8	1	

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

9. BIRTHPLACE (CITY OR TOWN) Clay County,
(STATE OR COUNTRY) Missouri,

PARENTS
10. NAME OF FATHER John E. Taylor,
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown,
(STATE OR COUNTRY) Kentucky,
12. MAIDEN NAME OF MOTHER Mary E. Fitzgerald
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown,
(STATE OR COUNTRY) Illinois,

14. INFORMANT L. B. Hawkins
(Address) 2010 South 11th. Street.

15. FILED SEP 22 1927 John G. Uth
REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 20, 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1927, to Sept. 20, 1927 that I last saw her alive on 12 m. Sept 20, 1927, and that death occurred, on the date stated above, at 1:50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Saw her only once at Mo. Methodist Hospital was in collapse then septic from miscarriage from perforated womb (duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) Don't Remember (duration) yrs. mos. ds.

140

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? yes perforation fundus

WHAT TEST CONFIRMED DIAGNOSIS? of womb

(Signed) Jacob Bergsma E. Bergsma M.D.

Sept 24, 1927 (Address) St Joseph Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Gower, Mo. DATE OF BURIAL Sept. 23 1927.

20. UNDERTAKER Heaton-Belsa Und. Co. by J. M. Karle ADDRESS 519 S. 10 St. St. Joseph, Mo.

N. B.—Blank should be signed EXACTLY as filled. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH should be properly stated, for it may be properly classified.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Buchanan — Registration District No. 85 — File No.

Township — Primary Registration District No. 1001 — Registered No. 968

City St. Joseph (No. ..... St. ..... Ward)

2. FULL NAME Verna Mae Hawkins

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 4/12, 1927 John G. Utz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 20 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19..., that I last saw h..... alive on ....., 19..., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Saw her only once at Mo. Methodist Hospital was in Collapse then Sepsis & Hemorrhage from perforated Swomb (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Think it was from abortion performed by self or some one (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? No reliable history

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT LESS CONFIRMED DIAGNOSIS? .....

(Signed) Jas. O. Geiger M. D

Nov. 10, 1927 (Address) St. Joseph Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

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

SUPPLEMENTARY

N. B.—Every ... information should be carefully ... AGE should be stated EXACT ... CAUSE OF DEATH ... so that it may be properly classified. Exact statement of ... important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW