

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township St. James
City St. J.

Registration District No. 399
Primary Registration District No. 1002
(No. St. Joseph Hosp.)

File No. 17264
Registered No. 2238
St. _____ Ward _____

2. FULL NAME

Mrs Anna J Hawkins
(a) Residence. No. _____ St. _____ Ward. Brunswick Mo
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 1 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 23rd 1888

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
39 8 27

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)

(STATE OR COUNTRY) Kans

10. NAME OF FATHER

F. B. Spears

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER

Precilia Owens

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ohio

14. INFORMANT

Geo Spears
(Address) Brunswick Mo

15. FILED

7/21, 1928 M. M. Crowe
REGISTRAR Assn

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/20/28 19

17. I HEREBY CERTIFY, That I attended deceased from May 19, 1928 to May 20, 1928 that I last saw her alive on May 20, 1928, and that death occurred on the date stated above, at 9:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocardial thrombosis

CONTRIBUTORY (SECONDARY) Perforated intestine - general peritonitis
(duration) yrs. mos. 4 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) W. A. Poorman, M. D.
7/21, 1928 (Address) 452 Board Trade Bldg

*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

Elmwood Cemetery DATE OF BURIAL 5/27/28 19

20. UNDERTAKER

W. J. Mayberry Mo ADDRESS City

It should be noted that exact

--Every item

**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.....

Registration District No. 399

File No.

Township.....

Primary Registration District No. 1002

Registered No. 2236

City J. City (No.)

St.

Ward.....

2. FULL NAME

(a) Residence. No.
(Usual place of abode)

St.,

Ward.

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

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

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

5/21, 19 28

M. M. Browe
Ass

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-20 19 28

17.

I HEREBY CERTIFY That I attended deceased from 19....., 19.....

that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

mesenteric Thrombosis
Probably typhoid.

CONTRIBUTORY (SECONDARY)

Perforated intestine
general peritonitis

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) SA Brown, M. D.

, 19 (Address) 652 Board Trade

*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

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

SUPPLEMENTARY

5-17264