

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

Do not use this space.

25835

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City St. Louis (No. 4257, Hartford St. 7002 Ward)

**2. FULL NAME** Francis P. Hawkins

(a) Residence. No. 4257 Hartford St. 16 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 Male  
 4. COLOR OR RACE White  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 15, 1876

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	53	3	16	

**8. OCCUPATION OF DECEASED.**

(a) Trade, profession, or particular kind of work. Meat Cutter  
 (b) General nature of industry, business, or establishment in which employed (or employer). Retired  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis  
 (STATE OR COUNTRY) Mo.

PARENTS	10. NAME OF FATHER	Unknown
	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 Elizabeth Hawkins  
 (Address) 4257 Hartford

15. FILED 19 19 19 Registrar

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 1 1929

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..... 5:30 P. M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Asphyxiation due to fuel gas poisoning*  
 (duration)..... yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY) *Suicide*  
 (duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
 WAS THERE AN AUTOPSY?..... No

WHAT TEST CONFIRMED DIAGNOSIS  
 (Signed) *G. W. Ferner, M.D.*  
 7/3, 1929 (Address) *Dep. Coroner*

\*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  
 New Pieker Cemetery July 5 1929

20. UNDERTAKER ADDRESS 3732  
*Kauch & Schmidt* S. Grand Blv.

