APR 30 1930

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

Do not use this space.

9523

1. PLACE OF DEATH

County Marion — Registration District No. 552 — File No. 5

Township Warren — Primary Registration District No. 5745 — Registered No.

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

2. FULL NAME W. T. Hawker

(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: 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~~ Emma R Hawker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 3 1873

7. AGE: Years 57 — Months 2 — Days 8 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(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) Missouri

PARENTS

10. NAME OF FATHER Wm Hawker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Sarah Couch

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo

14. INFORMANT Gertrude Freshwater
(Address) Hannibal Mo

15. FILED 3/11 1930 Alta V. Wagner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 10 1930

17. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1930, to Mar 10 1930 that I last saw him alive on Mar 8 1930, and that death occurred, on the date stated above, at 8 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Dropsy

4 1/2 B

12 B (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (SECONDARY) —

(duration) — yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? at place of death

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Urine Analysis

(Signed) E M Mills M.D.

, 19 (Address)

*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: 200 Ft. Cem. Hannibal Mo

DATE OF BURIAL: 3/12 1930

20. UNDERTAKER: Grover G Gwin

ADDRESS: Hannibal Mo

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Marion — Registration District No.: 352 — File No.:
Township: Warren — Primary Registration District No.: 3-743 — Registered No.: 3-
City: ..... (No. ....., ... St. ..... Ward)

2. FULL NAME: W. F. Hawken

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Emma R Hawken

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

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	2	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(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): Missouri

PARENTS
10. NAME OF FATHER: Wm Hawken
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Missouri
12. MAIDEN NAME OF MOTHER: Gertrude Trischmann
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Missouri

14. INFORMANT: ..... (Address): Hunnewell Mo

15. FILED 3/11 1930 Alta V Wagner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 3/10 1930

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1930 to Mar 10 1930, that I last saw him alive on Mar 10 1930, and that death occurred, on the date stated above, at 8-15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Dropsy
caused by
malignant Tumor
(duration) 2 yrs. 1 mos. 1 ds.

CONTRIBUTORY (SECONDARY) 448
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? at place of death
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) O M Mills M.D. M.D.
, 19 (Address) Louisiana 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: Hunnewell Mo — DATE OF BURIAL: 3/12 1930
20. UNDERTAKER: Grover Givan — ADDRESS: Hunnewell Mo

SUPPLEMENTARY

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

Attention is called to the penal statutes in force in this state, as set forth in the rules and regulations of the State Board of Health, which provide that any physician who shall make a false statement of any material fact in any certificate of death, or who shall make a false statement of OCCUPATION is very important.

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