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

Do not use this space.

17725

791

1003

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. ..... Registered No. 4818.

City ..... (No. ISOLATION HOSPITAL St. 24th Ward)

2. FULL NAME Clyde Hawkins

(a) Residence. No. 6943 Sheridan 21 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) |
|---|---|---|
| Male | Colored | Single |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-19-28

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 1 | 10 | 21 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nil 25 32A

(b) General nature of industry, business, or establishment in which employed (or employer) 24A

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Luther Hawkins

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

12. MAIDEN NAME OF MOTHER Ollie B. Yancie

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

14. INFORMANT Joe Laffler
(Address) ISOLATION HOSPITAL

15. FILED ....., 19 Max C. Hardy REGISTRAR

## 3 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1930, to May 10, 1930 that I last saw him alive on May 10, 1930, and that death occurred, on the date stated above, at 11:45 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Miliary Tuberculosis of Intestines

? .....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) T.B. Meningitis

..... (duration) ..... yrs. ..... mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH .....

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

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [signature], M. D.

5-11, 1930 (Address) ISOLATION HOSPITAL

*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 |
|---|---|
| Duquion Ill | 5/17 1930 |
| **20. UNDERTAKER** | **ADDRESS** |
| Kement-son | 2700 Wash St |

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.