

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

Do not use this space.

18072

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital #1**)

File No.

Registered No. **5230**

St. Ward)

2. FULL NAME **Thomas S. Hawkins**

(a) Residence. No. **2513 Cass** St. **20** Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **8** 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) **Married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec. 11-1905**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
24 **5** **16**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Laborer**
(b) General nature of industry, business, or establishment in which employed (or employer) **Railroad Co**
(c) Name of employer **Mo. Pacific R.R.**

9. BIRTHPLACE (CITY OR TOWN) **Paduch**
(STATE OR COUNTRY) **Kentucky**

10. NAME OF FATHER **Jose Hawkins**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Shelby County**
(STATE OR COUNTRY) **Indiana**

12. MAIDEN NAME OF MOTHER **Grace Duke**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Crab Orchard**
(STATE OR COUNTRY) **Illinois**

14. INFORMANT **C. A. Hall**
(Address) **East St. Louis, Ill**

15. MAY 28 1930 FILED 1930 **May 28 1930**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 27th 1930**

17. **No** Physician in attendance. 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 **703 A** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Peritonitis, following Gunshot Wound of Back
173
129 (duration) yrs. mos. ds.

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

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

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

20. WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **W. H. Purkey**, M. D.
5/28, 1930 (Address) **St. Louis, 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 **St. Louis Cemetery** DATE OF BURIAL **May 29 1930**

20. UNDERTAKER **John Kasey** ADDRESS **St. Louis, Mo**

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.

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