OCT 28 1930

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

Do not use this space.

29155

1. PLACE OF DEATH

County Buchanan — Registration District No. 85 — File No.

Township — Primary Registration District No. 1001 — Registered No. 1005

City St. Joseph, (No. Noyes-Baptist Hospital St. Ward)

2. FULL NAME Bonnie Evelyn Hawkins,

(a) Residence. No. 220 E. Kansas Ave. St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 3 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)
Female	White	Married,

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 8th. 1905

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	24	10	29	

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) St. Joseph,
(STATE OR COUNTRY) Missouri,

PARENTS

10. NAME OF FATHER Unknown,

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

12. MAIDEN NAME OF MOTHER Floe Powell,

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

14. INFORMANT Wm M. Hawkins
(Address) 220 East Kansas Ave.

15. FILED SEP 9 1930 19 John G. Ut REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 7 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 3, 1930 to Sept 7 1930 that I last saw her alive on Sept 7, 1930 and that death occurred, on the date stated above, at 2:10 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diarrhea & Enteritis
141
120B
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY) Miscarriage 3 month
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Noyes Baptist Hosp

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Charles H. Werner M. D.

Sept 8, 1930 (Address) 315 Kirkpatrick 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	DATE OF BURIAL
Barnard, Mo. via auto	Sept. 9 1930
20. UNDERTAKER	**ADDRESS**
Heaton-Belgade-Bowman Funeral Home	319 S. 10 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.

WRITE PLAINLY, WITH UNFADING INK