

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

Do not use this space.

33925

1. PLACE OF DEATH

County St. Clair Registration District No. 766
 Township Rose Primary Registration District No. 60.11
 City _____ No. _____ St. _____ Ward _____

File No. _____
 Registered No. _____

2. FULL NAME

Velda Mae Hawkins
 (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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 23 - 1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
6 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none 182
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER John Hawkins

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

12. MAIDEN NAME OF MOTHER Dulah Beard

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

14. INFORMANT Father
 (Address) Oyer, Mo

15. FILED _____, 19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct-12-1930

17. I HEREBY CERTIFY, That I attended deceased from 9-15, 1930 to 10-6, 1930 that I last saw her alive on 10-6, 1930, and that death occurred, on the date stated above, at 9:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Supposed in crib, was found dead lying on face
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 180
 (duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS Post Mort
 (Signed) J. W. Richardson, 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 Oyer, Mo DATE OF BURIAL 10/12 1930

20. UNDERTAKER Edwards Adg. Mo ADDRESS _____

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Clair Registration District No. 766 File No.
 Township Roscoe Primary Registration District No. 6011 Registered No.
 City (No.) St. Ward)

2. FULL NAME

Velda Fae Hawkins

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

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. ds.
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

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
 - (Address)

15.

FILED 11/0, 1930 J. O. Plouffe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 12 1930

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw him alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (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?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., 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 DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF OCCUPATION IS VERY IMPORTANT. FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-33925