

WRITE PLAINLY, WITH OUPRADING MARKS

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.

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

Do not use this space.

MAY 25 1934

14834

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**
(No. *Memorial Homes 2609 S Grand*)

File No.....
Registered No. **4028**
St. Ward)

2. FULL NAME

Mr John F. Hawken
(a) Residence, No. *2609 S Grand* St., *17* Ward.
(Usual place of abode) *St Louis Mo.* (If nonresident, give city or town and State)
Length of residence in city or town where death occurred *50* 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) *Widowed*
6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Virginia Hawken*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Nov. 16 - 1860*
7. AGE YEARS *73* MONTHS *5* DAYS *4* IF LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as planner, sawyer, bookkeeper, etc. *Supp. Storekeeper*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Retired*
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

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

13. NAME *Otis R. Hawken*

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

15. MAIDEN NAME *Lilla B. Long*

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

17. INFORMANT *Mrs Susan S Shaw*
(ADDRESS) *2609 S Grand*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Sellefontaine Cem* DATE *April 21* 1934

19. UNDERTAKER *Loaic Undertaking Co.*
(ADDRESS) *4416 S Washington St*

20. FILED *4/20/34*
19 *34* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *APR 20 1934* 19

22. I HEREBY CERTIFY, That I attended deceased from *April 10* 1934, to *April 20* 1934
I last saw him alive on *April 19* 1934. Death is said to have occurred on the date stated above, at *10* m.

The principal cause of death and related causes of importance were as follows:

Angina Pectoris
MI
Other contributory causes of importance: *MI*
Date of onset *4/10/34*

Name of operation..... Date of.....
What test confirmed diagnosis? *Ecmy* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify.....
(Signed) *W. B. Anglerhede* M. D.
(Address) *3109 Ansel St*

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