

DECEMBER 10 1938

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

2317
Do not use this space.

1. PLACE OF DEATH **GREENE** Registration District No. **316**
 (a) County.....
 (b) Township..... Primary Registration District No. **2001** Registered No. **52**
 (c) City **SPRINGFIELD** (d) Street No. **310 W. Pacific** St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
25 1/2 James Morton Hawkins
 2. PRINT FULL NAME **310 W. Pacific**
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widower**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Sep. 5 - 1854**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
84 4 14
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Retired Laborer**
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **January 19, 1939**
 22. I HEREBY CERTIFY That I attended deceased from **Jan 6**, 19**39**, to **Jan 14**, 19**39**.
 I last saw him alive on **Jan 11**, 19**39**. Death is said to have occurred on the date stated above, at **8:30 p.m.**
 The principal cause of death and related causes of importance were as follows:
Chronic Hypertensive Cardiovascular disease renal disease
 Date of onset _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ill.**
 FATHER 13. NAME **Martin Hawkins**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**
 MOTHER 15. MAIDEN NAME **Unknown**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**
 17. INFORMANT **J. D. Hawkins**
 (ADDRESS) **Springfield, Mo.**

Other contributory causes of importance: **121**
 Name of operation _____ Date of _____
 What test confirmed diagnosis? **clinical** 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.

18. BURIAL, CREMATION, OR REMOVAL **East Lawn** DATE **Jan. 21, 1939**
 19. FUNERAL DIRECTOR (NAME) **J. W. Huggins**
 (ADDRESS) **Springfield, Mo.**
 20. FILED **1-31** 19**39** **Chas. A. George** Local Registrar

Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? **No**
 If so, specify _____
 (Signed) **Arthur D. Knapp** M. D.
 (Address) **420 W. E. Canal St.**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____

_____, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. 3358

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.