

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

24814
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Itaw Primary Registration District No. 1007
 (c) City Ita Mo (d) Street No. 17 E Sun Street Registered No. 3027
 (e) Length of residence in city or town where death occurred yrs. mos. da. (If death occurred in Hospital or Institution, write its name instead of street and number)
 (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Bertie Hawkins
 (a) Residence, No. 2509 Hoast St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAY 30 1880

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
78 7 27

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
 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.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ita Mo

FATHER
 13. NAME James Arnold
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ita Mo

MOTHER
 15. MAIDEN NAME unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ita Mo

17. INFORMANT (ADDRESS) Robert Clark
17 E Sun Street

18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Springs Mo 7-29-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. B. Webb
Blue Springs Mo

20. FILED July 28, 1939 M. M. Crow
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-27-39

22. I HEREBY CERTIFY, That I attended deceased from 7-26-39, 1939, to 7-27-39, 1939.
 I last saw him alive on 7-27-39 Death is said to have occurred on the date stated above, at 4:30.
 The principal cause of death and related causes of importance were as follows:
arteriosclerotic Heart Disease
hypostatic Pneumonia
 Date of onset

Other contributory causes of importance:
hypostatic Pneumonia

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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? _____
 If so, specify _____
 (Signed) Dr. De Maria M. D.
Dr. H. C. Sun Street (Address)

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.

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. _____

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.