

Registration District No. 70

Primary Registration District No. 5937C

1. PLACE OF DEATH:  
(a) County Polk Mo.  
(b) City or town Madison Mo  
(c) Name of hospital or institution: RTO 2  
(If outside city or town limits, write "RURAL" and name of township)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
In this community all of life (Specify whether years, months or days)

3. (a) PRINT FULL NAME John F Hawkins  
3. (b) If veteran \_\_\_\_\_ name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex male  
5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Lucretia Anne  
6. (c) Age of husband or wife if alive 66 years  
7. Birth date of deceased March 7-1865  
(Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 10 hr. \_\_\_\_\_ min. \_\_\_\_\_  
If less than one day

9. Birthplace Polk Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
12. Name John Hawkins  
13. Birthplace Ky  
(City, town, or county) (State or foreign country)  
14. Maiden name Martha Haller  
(City, town, or county) (State or foreign country)  
15. Birthplace Don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dr. J. H. Hawkins  
(b) Address Madison Mo

17. (a) Burial (b) Date thereof 11-19-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Star Ridge

18. (a) Signature of funeral director Shuteson Blue  
(b) Address Madison Mo

19. (a) Dec 1-39 (b) Maljumental  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Polk  
(c) City or town Madison  
(If outside city or town limits, write "RURAL")  
(d) Street No. R Route  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 11 day 17  
year 1939 hour 10 minute 45 P.M.

21. I hereby certify that I attended the deceased from 11/11 to 11/17, 1939  
that I last saw him alive on 11/16, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Pneumonia  
Influenza  
Due to Acute Pneumonia  
Influenza

Due to 11/17  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature L. A. G. G. G. G. (M. D. or other) \_\_\_\_\_  
Address Madison Mo Date signed 11/17/39

Duration 9 days  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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.

RECEIVED

District Health Officer No. 73

District No. (Number) 2-39-1752

Date Filed 12-21-37

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**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.**