

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 101

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1108 Rock St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days) AKO

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Marion
(c) City or town Hannibal
(If outside city or town limits, write "RURAL")
(d) Street No. 1108 Rock St
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Ladonia Hawkins
3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar. day 9
year 1940 hour 2 minute 25 A.M.

4. Sex Female 5. Color of race col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Wm J Hawkins
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased. 6 4 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 1, 1940, to March 9, 1940;
that I last saw her alive on 3/9/40, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

8. AGE: Years Months Days If less than one day
64 6 9 5 hr. _____ min.

Due to Influenza
Due to Dehens of debility

9. Birthplace Bowling Green Mo
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation House Wife

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

MOTHER FATHER { 12. Name Geo Wilson
18. Birthplace Mo
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name _____
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Arizona Stennus
(b) Address Philadelphia Penn

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof 3 12 - 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)

(c) Place: burial or cremation Robinson bur.
18. (a) Signature of funeral director Geo E Roberts
(b) Address Hannibal Mo

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
White at work? _____ (Specify type of place)
(e) Means of injury _____

19. (a) Mar 19 1940 (b) W C Fushes
(Date received local registrar) (Registrar's signature)

23. Signature W C Fushes (M. D. or other) _____
Address Hannibal Date signed 3/9/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39

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.

PHYSICIAN
Underline the cause to which death should be charged statistically

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.....

Geo E Roberts....., Registered Apprentice No.....
working under my personal supervision.

Signed *Geo E Roberts*.....

Licensed Embalmer No *2113*.....

P. O. Address *Hannibal Mo*.....

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.