

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

26695

State File No.

REG SEP 25 1940
791

Registration District No.

Primary Registration District No. 1003

Registrar's No. 6591

1. PLACE OF DEATH:

(a) County _____
(b) City or town Missouri Pacific Hospital
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis Mo.
(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

3. (a) PRINT FULL NAME John Henry Hawkins
3. (b) If veteran, name war no 3. (c) Social Security No. 702-14-9013

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Parlie 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased June 20, 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 1 12 hr. min.

9. Birthplace Kinsley Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Foreman

11. Industry or business Mo. Pac., Railroad

MOTHER FATHER { 12. Name Michael Hawkins
18. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Delia McMahon
16. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant P. Parlie Hawkins

(b) Address Hurst Illinois

17. (a) Burial (b) Date thereof 8-4-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Atchison Illinois

18. (a) Signature of funeral director W. J. Ambuster

(b) Address 6633 Clayton Road

19. (a) AUG 2 1940 (b) J. G. Prudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____
(c) City or town Hurst
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2
year 1940 hour 8 minute 50 A.M.
21. I hereby certify that I attended the deceased from 7/31/40
8/2/40 19 to 8-2-40 19
that I last saw him alive on 8/2/40 19
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy
Hypertension
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

Duration 3 days
PHYSICIAN
Underline the cause to which death should be charged statistically.

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? _____

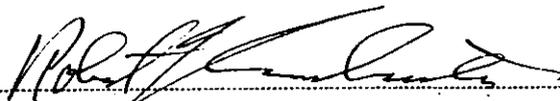
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Charles C. Dracy (M. D. or other) MD
Address 1755th Street Date signed 8/2/40

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

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. 1994

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.