

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31218
Registrar's No. 3781

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

Jackson

(a) County _____
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days
(Specify whether
In this community 23 Years
years, months or days)

3. (a) PRINT FULL NAME JOHN A. HAWKINS
3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex Male
5. Color or race Wh.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Bertha Hawkins
6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased March 4, 1876
(Month) (Day) (Year)

8. AGE: Years 64 Months 6 Days 23
If less than one day
hr. _____ min. _____

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

10. Usual occupation Mauser

11. Industry or business _____

12. Name Henry Hawkins

13. Birthplace Va.
(City, town, or county) (State or foreign country)

14. Maiden name Fannie Rice

15. Birthplace Va.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bertha Hawkins

(b) Address 1807 Brownell

17. (a) Burial (b) Date thereof 10/1/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 618 Brooklyn, K. C. Mo.

19. (a) 9-30-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limit, write "RURAL")
(d) Street No. 1807 Brownell
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27th
year 1940 hour 7 minute 20 P. M.

21. I hereby certify that I attended the deceased from Sept. 18th, 1940 to Sept. 27th, 1940

that I last saw him alive on Sept. 27th, 1940, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertrophy of prostate
Duration _____

Due to _____

Due to _____

Other conditions 137
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy None

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) (a) Means of injury _____

23. Signature Amey R. Thorne (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital, K.C. Mo. Date signed _____

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 *Renzil C. Browning*

Licensed Embalmer No. 2724

P. O. Address H. C. No

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

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