

JAN 23 1944

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 44067

Registration District No. 834

Primary Registration District No. 4503

Registrar's No. 34

1. PLACE OF DEATH:  
(a) County Stoddard  
(b) City or town Advance  
(c) Name of hospital or institution:  
Advance, 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

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Francis  
(c) City or town Flat River  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location) 0  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov day 9  
year 1940 hour 8 minute 45 P. M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Winess Hawkins 6. (c) Age of husband or wife if alive 37 years  
7. Birth date of deceased Dec. 13, 1901  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above

8. AGE:	Years	Months	Days	If less than one day
	<u>38</u>	<u>10</u>	<u>26</u>	hr. _____ min. _____

Immediate cause of death gun shot wound thru heart  
Due to 28 November

9. Birthplace Stoddard Co. Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Carpenter

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 172

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name James Hawkins  
13. Birthplace Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Carrie Gable  
15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Winess Hawkins  
(b) Address Flat River, Mo.  
17. (a) Drews Cemetery (b) Date thereof Nov 12, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Drews Cemetery Mo.  
18. (a) Signature of funeral director Clayton D. Morgan  
(b) Address Advance, Mo.  
19. (a) 11-15-1940 (b) D. S. McKeel 750  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Homicide  
(b) Date of occurrence 11/9/40  
(c) Where did injury occur? Advance, Stoddard Co.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, or industrial place, in public place?  
Street of Advance  
While at work? \_\_\_\_\_ (Specify type of place)  
(b) Means of injury \_\_\_\_\_  
23. Signature John H. [unclear] (M. D. or other) \_\_\_\_\_  
Address Flat River, Mo. Date signed 11/9/40

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

RECEIVED

District Health Office

District File Number 41

Date Filed 1/8

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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.....

Lloyd S. Morgan....., Registered Apprentice No.....  
working under my personal supervision.

Signed

Lloyd S. Morgan

Licensed Embalmer No. 336

P. O. Address Advance, TN

**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, fact should be so stated above.**