DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 20 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3352

Registration District No. 530 Primary Registration District No. 5708 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Rural - Easley Ann

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon

(c) City or town - Rural -

(If outside city or town limits, write "RURAL")

(d) Street No. North east of Elmer Mo

(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME ARMINTIA HAWKINS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife George Hawkins

6. (c) Age of husband or wife if alive years

7. Birth date of deceased September 20 - 1862 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
78	3	14	hr. min.

9. Birthplace Cole County Ill. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Harley Hawkins

(b) Address Elmer, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Helton

18. (a) Signature of funeral director Clyde McCollum

(b) Address Elmer, Mo.

19. (a) Jan 10 41 (Date received local registrar) (b) Mrs Lloyd [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 Jan day 1941 year 1941 hour 7 45 minute a M.

21. I hereby certify that I attended the deceased from Jan 2, 1941 to Jan 3, 1941; that I last saw her alive on Jan 2, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Drophsy & Congestion of Lung

Due to Cold

Due to Tumor

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations no

Of autopsy no

Duration

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? 472 (Specify type of place)

While at work? (e) Means of injury

23. Signature W H Gooch (M. D. or other)

Address Elmer Mo Date signed Jan 3 41

(Licensed Embalmer's Statement on Reverse Side)

562

RECEIVED
District Health Officer No. 10
District File Number 1-41-154
Date Filed JAN 16 1941

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 Clyde McCallum

Licensed Embalmer No. 3226

P. O. Address Elmer, 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.

No. 2B
-2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3352

Registration District No. 530 Primary Registration District No. 5708 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Macon

(b) ~~City or town~~ Easley T.P.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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.

3. (a) PRINT FULL NAME Armintia Hawkins

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days 14 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3
year 19 hour minute M.

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.

Immediate cause of death Dropsy and congestion of lung

Due to Cold

Due to Tumor 56 %

Other conditions N. M. D. —
(Include pregnancy within 3 months of death)

Physician is now deceased —

Major findings:
Of operations
Of autopsy

Duration

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed