

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 17479

Registration District No. 138

Primary Registration District No. 4078

Registrar's No. 83

1. PLACE OF DEATH:

(a) County **Carroll**  
 (b) City or town **Norborne,**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**Cole Hospital.**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **three weeks.**  
(Specify whether  
 In this community **life.** **Five** (Specify whether  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri.** (b) County **Carroll**  
 (c) City or town **Norborne, Mo. RFD.**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME **MARTHA ESTLE 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 **Married.**

6. (b) Name of husband or wife **Grover Hawkins,** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **May 28th, 1892.**  
(Month) (Day) (Year)

8. AGE: Years **48** Months **11** Days **4** If less than one day hr. **1** min.

9. Birthplace **Carroll County.** **✓ 0**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife.**

11. Industry or business \_\_\_\_\_

12. Name **Robert J. Brock,**

13. Birthplace **Carroll County, Mo.** **0**  
(City, town, or county) (State or foreign country)

14. Maiden name **Cora E. Robinson,**

15. Birthplace **Carroll County, Mo.** **0**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Grover Hawkins,**

(b) Address **Norborne, Mo.**

17. (a) **Burial.** (b) Date thereof **5/4/1941.**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **FairHaven, Norborne, Mo.**

18. (a) Signature of funeral director **Clifford W. Austin,**

(b) Address **Tina, Mo.**

19. (a) **May 3 1941** (b) **B. C. Cole**  
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month **May** day **2nd,**  
 year **1941.** hour **1** minute **0** **P.**-M.

21. I hereby certify that I attended the deceased from **4-1-41**  
 \_\_\_\_\_, 19\_\_\_\_, to **5-2-** \_\_\_\_\_, 19**41**  
 that I last saw her alive on **5-2-** \_\_\_\_\_, 19**41**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Malignant Hypertension. 3-7mo.**  
 Due to **Respiratory Failure**

Due to \_\_\_\_\_  
 Other conditions **Nitrogen retention** **Deposit**  
(Include pregnancy within 3 months of death) **Kidney**

Major findings: Of operations \_\_\_\_\_  
 Of autopsy **102**

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?

23. Signature **B. C. Cole** (M. D. or other) **1**  
 Address **Norborne, Mo.** Date signed **May 2-41**

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

7  
2  
0

RECEIVED  
District Health Officer No. 8  
District File Number  
Date Filed 6-6-41

**STATEMENT BY LICENSED EMBALMER**

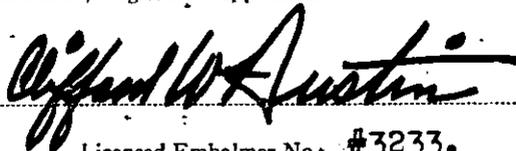
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

**Clifford W. Austin,**

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No.: #3233.

P. O. Address: Tina, Missouri.

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 17479

Registration District No. 138

Primary Registration District No. 4025

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Norborne  
(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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Martha Estle Hawkins

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month May day 2  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

Immediate cause of death \_\_\_\_\_

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

8. AGE: Years 48 Months 11 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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? \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 7-19-1941 (b) B. C. Cole  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature B. C. Cole (M. D. or other) \_\_\_\_\_  
Address Norborne Mo Date signed \_\_\_\_\_

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

SUPPLEMENTAL

6-11-57