

FILED JUN 10 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17978

Registration District No. 318

Primary Registration District No. 5440

Registrar's No. 353

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield Rural S Campbell
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
MEDICAL CENTER FOR FEDERAL PRISONERS 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 Mos., 20 days
(Specify whether
In this community 8 Mos., 20 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Texas (b) County Navarro
(c) City or town Corsicana
(If outside city or town limits, write "RURAL")
(d) Street No. 711 East Third Avenue
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4th
year 1942 hour 4 minute 45 PM.
21. I hereby certify that I attended the deceased from August
15, 1941, to May 4, 1942, 1942,
that I last saw him alive on May 4, 1942,
and that death occurred on the date and hour stated above.

Immediate cause of death Dilatation of heart, acute
Duration 30 min.

Due to Asthma, bronchial 9 mos. plus.

Due to _____
Other conditions 95C4
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
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 E. Calaberry (M. Death) 0
Clinical Director
Address MCFP, Springfield, Mo. Date signed 5-5-42

3. (a) PRINT FULL NAME HAWKINS, James

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

4. Sex Male 2 5. Color or race Negro 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Delia (Shepard) Hawkins 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased August 5 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 8 29 hr. min.

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

10. Usual occupation Oil Mill Laborer

11. Industry or business Cottonseed Oil Mills

MOTHER FATHER { 12. Name Arnison Hawkins

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

14. Maiden name Ann. (maiden name unknown)

15. Birthplace unknown 1 Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant deceased

(b) Address _____

17. (a) Removal (b) Date thereof 5/5/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Corsicana, Texas

18. (a) Signature of funeral director Thieme

(b) Address Springfield, Mo.

19. (a) 5-5-42 (b) D. W. S. Handley
(Date received local registrar) (Registrar's signature)

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..... *R. Christie*

Licensed Embalmer No. *3681*

P. O. Address. *Springfield, 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, fact should be so stated above.

X