

No. 2
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-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22811
6437

FILED AUG 6 1942

State File No.

Registration District No. 1911

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 Days
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 17

(c) City or town St. Louis 219
(If outside city or town limits, write "RURAL")

(d) Street No. 3011 Easton Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME Hawkins

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race Negro

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____

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

7. Birth date of deceased 7 2 42
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
NB			13	6 hr. 31 min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name Ida Bell Hawkins

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

16. (a) Informant Father, Mrs. Sherard K. K.

(b) Address 2601 N. Whittier Street

17. (a) Burial (b) Date thereof JUL 31 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Ira Hamilton

(b) Address City Health Dept

19. (a) JUL 30 1942 (b) J. F. Bredeck
(Date entered on certificate) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 15
year 42 hour 6 minute 8 A. M.

21. I hereby certify that I attended the deceased from 11:29 am
7 - 2, 19 42 to 6:00 a.m. 7-15, 19 42
that I last saw her alive on 7 - 15, 19 42
and that death occurred on the date and hour stated above.

Immediate cause of death
Hemorrhage
Neonatorum

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

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? 0

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

23. Signature J. F. Bredeck (M. D. or other) _____

Address 2601 N. Whittier St. Date signed 7-27-42

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

MOTHER FATHER

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22811
Registrar's No. 6437

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Hosp. James H. Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 days
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME.....

Hawkins

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex..... F 5. Color or race..... B 6. (a) Single, widowed, married, divorced.....

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

7. Birth date of deceased..... July 2 1942
(Month) (Day) (Year)

8. AGE: Years Months Days (If less than one day) min.

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

10. Usual occupation.....

11. Industry or business.....

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)

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof Jul. 31-1942
(Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) SEP 5 1942 J. F. Brudeak
(Date received local registrar) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 2 Year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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)
(e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-22811