DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

31615

State File No.

FILED OCT 6 1942

Registration District No. 364 Primary Registration District No. 6237 Registrar's No. 16

1. PLACE OF DEATH:
(a) County WARREN, MO.
(b) City or town Rural Twp
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County WARREN
(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 TILLIE HAWKINS
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex F 3
5. Color or race Col
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Wm Hawkins
6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased 11 (Month) 17 (Day) 1890 (Year)
8. AGE: Years 51 Months 10 Days 9 If less than one day hr. min.
9. Birthplace Missouri (City, town, or county) WARREN Co. (State or foreign country)
10. Usual occupation
11. Industry or business Housekeeper
MOTHER FATHER
12. Name Wm Simms
13. Birthplace Warren Co Mo. (City, town, or county) (State or foreign country)
14. Maiden name Matilda Edwards
15. Birthplace Warren Co Mo. (City, town, or county) (State or foreign country)
16. (a) Informant Wm Hawkins
(b) Address 2710 Standard St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 1 42 (Month) (Day) (Year)
(c) Place: burial or cremation Wright City Mo
18. (a) Signature of funeral director G. L. Walton
(b) Address 2307 Standard St
19. (a) Sept 29-42 (Date received local registrar) (b) Julius Niebung (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 26 year 42 hour 7 minute 30 A. M.
21. I hereby certify that I attended the deceased from June 30 1939 to Sept 26 1942 that I last saw her alive on 11 11 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Mitral Insufficiency	3 Yrs
Due to Nephritis (Chronic Interstitial)	4 Yrs
Due to	
Other conditions (Include pregnancy within 3 months of death) 13/a	

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 D. E. Taylor (M. D. or other)
Address 3136 Chouteau Date signed 9/28/42

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

1281 (Licensed Embalmer's Statement on Reverse Side)

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 Arthur L Holliard

Licensed Embalmer No. 4221

P. O. Address 2649 a Delmar Be

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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. 31615

Registration District No. 364 Primary Registration District No. 6237 Registrar's No. 16

1. PLACE OF DEATH:

(a) County: Warren

(b) City or town: Rural Hickory Grove
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: West of Wright City, Mo
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Warren

(c) City or town: Rural
(If outside city or town limits, write "RURAL")

(d) Street No.: West of Wright City, Mo
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: Lillie Hankins

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: M

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

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

7. Birth date of deceased: Nov. 17 1890
(Month) (Day) (Year)

8. AGE: Years 51 Months 10 Days 8 (If less than one day: hr. ..... min.)

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

10. Usual occupation .....

11. Industry or business .....

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)

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 Sept. day 26 year 1942 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	Duration
Due to	
Due to	
Other conditions (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? .....

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

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

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

SUPPLEMENTARY