S. No. 2
M—1-4-41
. 5-17-39
I X26390

51
0
0

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 28 1943

Registration District No. 168

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5611

State File No. 22649

Registrar's No.

51

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Warrensburg, R.R. No. 3
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Residence / Pantowell Inn
(If not in hospital or institution, write street number or location)

(d) Length of stay: ~~In hospital or institution~~ 50 yrs.
(Specify whether years, months or days)

In this community 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson

(c) City or town R.F.D. No. 3 - Warrensburg
(If outside city or town limits, write "RURAL")

(d) Street No. No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Felix H. Hawthorne

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Robbie E. Hawthorne

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased Sept. (Month) 21, (Day) 1885 (Year)

8. AGE:

Years	Months	Days	If less than one day
65	4	0	hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name William Hawthorne
13. Birthplace Howard Co. (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Rebica Ridgway
15. Birthplace Howard Co. (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Willard Hawthorne
(b) Address Leeton, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-43 (Month) (Day) (Year)
(c) Place: burial or cremation Pleasant Bethel

18. (a) Signature of funeral director R.A. Brauninger
(b) Address Leeton, Mo.

19. (a) 1-22-43 (Date received local registrar) (b) R.A. Brauninger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 21, year 1943 hour 3:45 minute — A.M.

21. I hereby certify that I attended the deceased from 12-11-42 to 1/21/43 1943 that I last saw him alive on 1/21/43 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia — Duration 2 yrs.
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Pa Pestau (M.D. or other) D.O.
Address Leeton, Mo. Date signed 1/22/43

1024

(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 me, Registered ~~Apprentice~~ No. 3377, working under my personal supervision.

Signed R. A. Braunsinger

Licensed Embalmer No. 3377

P. O. Address Leeton, Missouri

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.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2649

Registration District No. 168 Primary Registration District No. 5611 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Johnson
(b) City or town Warrensburg
(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 (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 Felix H. Hawthorne
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
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 Sept. 21, 18[redacted] (Month) (Day) (Year)
9-21-1877

8. AGE: Years 65 Months 4 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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 January day 21
year 1943 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him 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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY