No. 2
11-10-39
-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 10 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7914

Registration District No. 356 Primary Registration District No. 4-5-21-6209 Registrar's No. 7

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

1. PLACE OF DEATH:
(a) County TEXAS
(b) City or town HOUSTON PINEY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Twp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 8 YRS
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 106
(a) State MISSOURI (b) County TEXAS
(c) City or town HOUSTON
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME MARY PHILLIPS HAWKINS
3. (b) If veteran, name war
3. (c) Social Security No. NONE
4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife CLARENCE HAWKINS
6. (c) Age of husband or wife if alive years
7. Birth date of deceased SEPT (Month) 22 (Day) 1878 (Year)

8. AGE: Years 64 Months 4 Days 22 If less than one day hr. min.

9. Birthplace (City, town, or county) ILL. (State or foreign country)
10. Usual occupation HOUSE WIFE
11. Industry or business
FATHER
12. Name SAMUEL PHILLIPS
13. Birthplace (City, town, or county) WE. VA. (State or foreign country)
MOTHER
14. Maiden name NANCY MONTGOMERY
15. Birthplace (City, town, or county) KY (State or foreign country)
16. (a) Informant CORA PHILLIPS
(b) Address HOUSTON, MO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/15/43 (Month) (Day) (Year)
(c) Place: burial or cremation OZARK
18. (a) Signature of funeral director Gaylord V. Elliott
(b) Address HOUSTON, MO
19. (a) Feb. 22-43 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 14
1943 year 2 hour minute A.M.
21. I hereby certify that I attended the deceased from JAN. 25, 1943, to Feb 14, 1943
that I last saw her alive on Feb 13, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death TUBERCULOSIS. CHR.	
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 Chas R Ozias (M. D. or other) MD
Address Houston, Mo Date signed 2-16-43

1240 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 343155.
Date Filed 2-8-42.

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 Frank E. Wood

Licensed Embalmer No. 4026

P. O. Address Houston, Mo

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

If this body is not embalmed, above space should be left blank.

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. 7914

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

1. PLACE OF DEATH:

(a) County Texas

(b) City or town Houston
(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 8 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Texas

(c) City or town Houston
(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 Mary P. 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 W

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

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

7. Birth date of deceased Sept - 22 - 1878
(Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days 22 If less than one day ..... hr. ..... min

9. Birthplace ..... (City, town, or county) Ill (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)

MOTHER FATHER
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) Mrs. Ella Duff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14
year 1943 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 Tuberculosis chr. Lungs

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.

13 b

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

23. Signature ..... (M. D. or other) .....
Address ..... Date signed M. D.

SUPPLEMENTARY