

AUG 18 1943
Registration District No. **1818**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... **St. Louis, Missouri**
(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 **1 mo. 24 days**
(Specify whether
 In this community **Life**
years, months or days)

3. (a) PRINT FULL NAME **Frankie Jones Hawthorne**

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

4. Sex **female** 5. Color or race **col** 6. (a) Single, widowed, married, divorced **married**

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

7. Birth date of deceased **July 26th 1907**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	36	0	10 hr. min.

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

10. Usual occupation **Housework**

11. Industry or business.....

12. Name **Frank H. Jones**

13. Birthplace **Mobile Ala**
(City, town, or county) (State or foreign country)

14. Maiden name **Amelia Bourrough**

15. Birthplace **Mobile Ala**
(City, town, or county) (State or foreign country)

16. (a) Informant **Rev Frank H. Jones**

(b) Address **4229W Garfield Ave**

17. (a) **Burial** (b) Date thereof **8/10/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood Cemetery**

18. (a) Signature of funeral director **J.H. Randle & Son**

(b) Address **3133 Bell Avenue**

19. (a) **AUG 9 1943** (b) **J.F. Bredbeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
 (c) City or town **St. Louis,**
(If outside city or town limits, write "RURAL")
 (d) Street No. **3128 Bell**
(If rural, give location)
 (e) Citizen of foreign country?..... **0** (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **6,**
year **1943** hour **10** minute **45** P. M.

21. I hereby certify that I attended the deceased from **June 13,** 19**43,** to **August 6,** 19**43**
that I last saw her alive on **August 6,** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Carcinoma of left Breast with metastasis to skin & subcutaneous tissues
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 **C. M. Jackson** M. D. or other.....
Address **2601 Webster** Date signed **8/14/43**

Duration
Unk.

PHYSICIAN
Underline the cause to which death should be charged statistically.

