

DEC 27 1943
Registration District No. 120

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
958 W. PACIFIC
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 DAYS
(Specify whether
In this community 18 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 39
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL") 6
(d) Street No. 958 W. Pacific
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country — 0

3. (a) PRINT FULL NAME HARRIET P. HAWKINS

3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife DELMORE HAWKINS
6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased February 26 1867
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>76</u>	<u>9</u>	<u>14</u>	hr.	min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name George P. Rolson
13. Birthplace Unknown Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Hellan Unk.
15. Birthplace Dorchester Mass.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs William Hawkins
(b) Address 958 W Pacific, Spfld, Mo

17. (a) Burial (b) Date thereof Dec 12 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn

18. (a) Signature of funeral director Fred C. Thiem
(b) Address Springfield, Missouri

19. (a) 12-11-43 (b) Dr W. H. Haudley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 10
year 1943 hour 5 minute 00 A.M.

21. I hereby certify that I attended the deceased from 6-14-43 19 to 12-10-43 19
that I last saw her alive on 12-9-43 19
and that death occurred on the date and hour stated above.

Immediate cause of death Degenerative Heart Disease & Decompensation
Due to Senility

Due to Fracture L. Femur

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: 133
(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) (z) Means of injury

23. Signature [Signature] (M. D. or other)
Address Springfield, Mo. Date signed 11-98

Duration
1 wk.
5 mo.
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

2
6

JUN 17 1957

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 Fred C. Thiem

Licensed Embalmer No. 2899

P. O. Address Springfield, Ind.

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.

X

Registration District No. 128

Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield, Mo.
(c) Name of hospital or institution:
(If outside city or town limits, give "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether

In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Harriet P. Harkins

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 sn

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

7. Birth date of deceased Feb 26 1866
(Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 9 If less than one day, min.

9. Birthplace Ohio
(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)

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 Jan year 1943 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 degenerative heart disease
decompensation

Due to senility

Due to Fracture of left femur 64X-83
Due to Fall from

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

Major findings:
Of operations..... 186a
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 [Signature] (M. D. or other).....
Address Springfield, Mo. Date signed.....

SUPPLEMENTARY

S-42271