

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 119

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Hannibal  
(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 1108 Rock ST years, months or days)

3. (a) PRINT FULL NAME Wm J Hawkins

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

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

6. (b) Name of husband or wife Ladonia Hawkins 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 7 (Month) 8 (Day) 68 (Year)

8. AGE: Years 76 Months 8 Days 21 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

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

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Wm Hawkins

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace Susan Smith (City, town, or county) Mo (State or foreign country)

16. (a) Informant Oliver Hawkins

(b) Address Detroit Michigan

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 (Month) 2 (Day) 1944 (Year)

(c) Place: burial or cremation Robinson Cem

18. (a) Signature of funeral director Jas E Roberts

(b) Address Hannibal Mo

19. (a) 4-2-44 (Date received local registrar) (b) R H Connor (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion

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

(d) Street No. 1108 Rock ST (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 29 year 44 hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from Jan 23-41 to Mar 29 1944 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Mitral Insufficiency

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) \_\_\_\_\_ means of injury \_\_\_\_\_

23. Signature H O M Necker (M. D. or other) \_\_\_\_\_

Address Hannibal Mo Date signed 4-29-44

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

**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.....  
*Geo E Roberts*  
Licensed Embalmer No. *2113*

P. O. Address.....

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

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