

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County **ST LOUIS**  
(b) City or town **ST LOUIS**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **DE PAUL Hosp**  
(If not in hospital or institution, write street number or location) **0**  
(d) Length of stay: In hospital or institution **1 wk** (Specify whether years, months or days) **37 yr**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **ST LOUIS** **96**  
(c) City or town **VALLEY PARK** **76**  
(If outside city or town limits, write "RURAL") **NR**  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **1**

3. (a) PRINT FULL NAME **EFFIE HAWK**  
(b) If veteran, name war **v** (c) Social Security No. **v**  
4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W 2**  
6. (b) Name of husband or wife **HENRY** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Nov 7 1895**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **June** day **24** year **1944** hour \_\_\_\_\_ minute **400 P.M.**  
21. I hereby certify that I attended the deceased from **5-19-44**, 19\_\_\_\_ to **5-24-44**, 19\_\_\_\_  
that I last saw her alive on **5-24-44**, 19\_\_\_\_ and that death occurred on the date and hour stated above.

8. AGE: Years **68** Months **7** Days **17** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death **Cerebral Hemorrhage** Duration **15 days**  
Due to **Don't know**  
Due to \_\_\_\_\_  
Other conditions **none**  
(Include pregnancy within 3 months of death)

9. Birthplace **RENAULT** **Ill.** (City, town, or county) (State or foreign country)  
10. Usual occupation **HOUSE WIFE**  
11. Industry or business **OWN HOME**  
12. Name **Wm SAWYER** **9**  
13. Birthplace **DO NOT KNOW** (City, town, or county) (State or foreign country)  
14. Maiden name **Josephine Hendricks**  
15. Birthplace **Ill.** (City, town, or county) (State or foreign country)

Major findings: Of operations **82** Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant **MARtha DOLAN**  
(b) Address **2847 So 4th - ST LOUIS Mo**  
17. (a) **BURIAL** (b) Date thereof **6-27-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **3100 Cem. 3100 Mo**  
18. (a) Signature of funeral director **ORTMANN FUNERAL HOME**  
(b) Address **2224 HIGHLAND OVERLAND Mo**  
19. (a) **JUN 28 1944** (Date received local registrar) **J. J. Prelick** (Registrar's signature)

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 **Walter H. Spoenemann, M.D.** (Physician)  
Address **1506 St Louis** Date signed **6-15-44**

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

0649

0649

**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 Al C Ostmann

Licensed Embalmer No. 3478

P. O. Address.....

**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.