S. No. 2
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 24 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

28752

State File No.

Registration District No. 379 Primary Registration District No. 6076 Registrar's No. 1742

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 9
Veterans' Administration Facility
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Adm. August 13, 1944 (Specify whether
In this community Since August 13, 1944
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 999

(a) State Illinois (b) County Saint Clair 11

(c) City or town Belleville 0
(If outside city or town limits, write "RURAL")

(d) Street No. 204 N. Illinois Ave.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - 2

3. (a) PRINT FULL NAME HAWTHORNE, Carl

3. (b) If veteran, name war W.W. #1

3. (c) Social Security No. Yes, not rem.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed.

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

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

7. Birth date of deceased October (Month) 31, (Day) 1897 (Year)

8. AGE: Years 46 Months 9 Days 16 If less than one day hr. - - min.

9. Birthplace Belleville, Illinois. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Railroad Worker.

11. Industry or business - -

FATHER
12. Name Thomas Hawthorne,
13. Birthplace unknown (City, town, or county) Unavail. 9 (State or foreign country)

MOTHER
14. Maiden name Sarah ?unknown
15. Birthplace unknown (City, town, or county) Unavail. 9 (State or foreign country)

16. (a) Informant M. Schilling Cl.Clk.,
(b) Address Vets.Adm.Fac., Jeff.Brks., Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/17/44 (Month) (Day) (Year)
(c) Place: burial or cremation Belleville, Ill.

18. (a) Signature of funeral director Lee Gardner
(b) Address Belleville, Ill.

19. (a) AUG 18 1944 (Date received local registrar) (b) E. D. McGavran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 17th
year 1944 hour 6:45 A.M. minute M.

21. I hereby certify that I attended the deceased from August 13, 1944 to August 17, 1944;
that I last saw him alive on August 17, 1944;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death CIRRHOSIS OF LIVER,	
TYPE UNDETERMINED.	UNKNOW
OTHER CONDITIONS: -	
HEMORRHAGE, INTESTINAL.	UNKN.
ANEMIA, SECONDARY.	UNKN.
(Include pregnancy within 3 months of death) 1241	

Major findings:
Of operations No Operation
Of autopsy Autopsy performed - See cause of death.

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) No
(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 W. A. GERMAN, M.D., (M. D. or other)
Address Chief Medical Officer, Jefferson Barracks, Mo. Date signed 8-17-44

107 (Licensed Embalmer's Statement on Reverse Side)

AUG 24 1944

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.

Body not embalmed.

Signed Lele Gardner

Licensed Embalmer No. .....

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.