

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: General Hospital No. 2 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8-17-44-9-5-44
(Specify whether years, months or days)
 In this community 26 years

3. (a) PRINT FULL NAME JOE HAWKINS

3. (b) If veteran, name war none
 3. (c) Social Security No. 595-03-0340

4. Sex Male 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Bessie Hawkins
 6. (c) Age of husband or wife if alive unk years
 7. Birth date of deceased February 25 1877
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>67</u>		<u>6</u>	<u>10</u>	hr. _____ min.

9. Birthplace Johnsonville Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business _____

MOTHER FATHER {
 12. Name Alfred Hawkins
 13. Birthplace Nashville Tenn.
(City, town, or county) (State or foreign country)
 14. Maiden name Alice
 15. Birthplace Humphrey Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
 (b) Address Gen. Hosp. #2

17. (a) burial (b) Date thereof 9-8-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cem.

18. (a) Signature of funeral director Watkins Bros.

(b) Address 1429 Lydia

19. (a) 9-8-44 (b) N. C. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 47
 (c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 2
 (d) Street No. 2637 Vine
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 5
 year 1944 hour 6:15 minute _____ P. M.

21. I hereby certify that I attended the deceased from August 17
1944 to September 5, 1944;

that I last saw him alive on September 5, 1944;
 and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerosis Duration

Due to Arterio Sclerotic type heart disease

Due to _____

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

Major findings: 93 2
 Of operations _____

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? _____

(Specify type of place) _____
 While at work? _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address Gen. Hosp. #2 600 E. 22nd Date signed 9-8-44

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.....

D. J. Manlove

Licensed Embalmer No.....

3994

P. O. Address.....

2503 Highland

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.