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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35953

FILED NOV 22 1944

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9644

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: D PARK LANE HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill (b) County Madison

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

(d) Street No. 1317 Madison Ave
(If rural, give location)

(e) Citizen of foreign country? NR (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME HARRY G. HAWK

3. (b) If veteran, name war

3. (c) Social Security No. 334-09-5356

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of ~~husband~~ or wife GERTURED

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased NOV (Month) 3 (Day) 1880 (Year)

8. AGE: Years 64 Months 0 Days 8 If less than one day hr. min.

9. Birthplace WINCHESTER (City, town, or county) ILL (State or foreign country)

10. Usual occupation JANITOR

11. Industry or business

FATHER
12. Name JOHN HAWK
13. Birthplace UNKOWN (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name UNKOWN
15. Birthplace UNKOWN (City, town, or county) (State or foreign country)

16. (a) Informant GERTURED HAWK
(b) Address 1317 MADISON AVE

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 11-11-1944 (Month) (Day) (Year)
(c) Place: burial or cremation MADISON ILL.

18. (a) Signature of funeral director LAHEY FUNERAL HOME
(b) Address MADISON ILL

19. (a) NOV 14 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 10th year 1944 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct. 17, 1944 to Nov. 10, 1944 that I last saw him alive on Nov. 10, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Acute dilatation of heart. — Duration 24 hrs

Due to Myocarditis - Acute secondary. — no. of years

~~Due to~~ Chronic gall bladder disease

Other conditions
(Include pregnancy within 3 months of death)

Major findings: Of operations Chronic cholecystitis with numerous adhesions and gall stones
~~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 Frank J. Smith M.D. (M.D. or other)

Address 4930 Lindell Date signed 11-11-44

(Licensed Embalmer's Statement on Reverse Side)

9644

9644

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 Ronald Yahike

Licensed Embalmer No. 3917

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.