

FILED SEP 13 1945

Registration District No. 2

Primary Registration District No. 4369

Registrar's No. 3

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

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Fairview
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 yrs
In this community 18 yrs
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton
(c) City or town Fairview
(If outside city or town limits, write "RURAL")
(d) Street No. 6
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sarah Madaline Hawkins

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Geo. Hawkins 6. (c) Age of husband or wife if alive Dead 1849
7. Birth date of deceased September 8 1849
(Month) (Day) (Year)

8. AGE: 95 Years 10 Months 23 Days
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name L. Lancaster
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Maines
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Andrew Hawkins

(b) Address Fairview, Mo.

17. (a) Burial (b) Date thereof Aug. 2 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rockiecomfort, Cem

18. (a) Signature of funeral director Wm. Manna Byrne

(b) Address Wheaton, Mo.

19. (a) 1945 (b) Orla Tanner by Mrs. Orla Tanner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31
year 1945 hour 11 minute P. M.

21. I hereby certify that I attended the deceased from July 1 to July 31, 1945,
that I last saw him alive on July 31, 1945,
and that death occurred on the date and hour stated above.
Immediate cause of death Coronary of heart
Duration 6 mo

Due to Coronary of heart

Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations HCK
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?

While at work? (Specify type of place) (e) Means of injury
23. Signature John Reardon (M. D. or other) Do
Address Wheaton Mo Date signed Aug 16 45

1481

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.

RECEIVED SEP 12 1945

Embalmer Officer No.

District File Number 945-161

Date Filed SEP 12 1945

Signed Wm. Marie Rogne

Licensed Embalmer No. 3942

P. O. Address Wheaton, Mo

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.