

FILED JAN 8 1946

Registration District No. _____

Primary Registration District No. **4025**

Registrar's No. **71**

1. PLACE OF DEATH:

(a) County **Barry**
(b) City or town **Wheaton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Wheaton 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 **Missouri** (b) County **Barry**
(c) City or town **Wheaton**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Andrew Pierce Hawkins**

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

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **---** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **October 7 1873**
(Month) (Day) (Year)

8. AGE: Years **72** Months **1** Days **20** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Last occupation Farming**

11. Industry or business _____

12. Name **G. A. Hawkins**

13. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

14. Maiden name **Sarah M. Lancaster**

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

16. (a) Informant **Mrs Will Nagle**

(b) Address **Wheaton, Mo.**

17. (a) **Burial** (b) Date thereof **Nov. 29/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rockycomfort, Mo.**

18. (a) Signature of funeral director **W. M. M. Squire**

(b) Address **Wheaton, Mo.**

19. (a) **Dec 7-1945** (b) **Grace Williams**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **27**
year **1945** hour _____ 5 minute _____ P. M.

21. I hereby certify that I attended the deceased from **June 1945** to **Nov 27 1945**
that I last saw him alive on **Nov 27 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Lymphatic Leukemia** Duration **8 mo**
Due to _____

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

Major findings: **740**
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? _____ Means of injury _____
23. Signature **John R. Ellison** (M. D. or other) **Dr**
Address **Wheaton Mo** Date signed **Dec 4, 1945**

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

MOTHER FATHER

1077

RECEIVED

District Health Officer No. 6,

District File Number 1245-1116

Date Filed 12-27-45

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 Wm Morris Ogne

Licensed Embalmer No. 3442

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.