

FILED MAR 14 1947

Registration District No. 517

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3066

State File No.

Registrar's No. 582

7217
582

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Kirkwood
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 8 Months years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96
(c) City or town Kirkwood 4
(If outside city or town limits, write "RURAL")
(d) Street No. 200 Saratoga St. 13
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Amanda Hawkins

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

4. Sex Female 5. Color or race Col. 6. (a) Single, widowed, married, divorced, Widow

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

7. Birth date of deceased Aug. 7 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 6 27 hr. min.

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Unknown 9

13. Birthplace Unknown 7
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Joe Hawkins

(b) Address 200 Saratoga St.

17. (a) Burial (b) Date thereof 3. 7 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centor MO.

18. (a) Signature of funeral director John W. Hemphill

(b) Address 408 S. Filmora Ave. Kirkwood

19. (a) 3-10-47 (b) Ruth J. Allen
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4
year 1947 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from 3-4-47 to 3-4-47
that I last saw him alive on 3-4-47 and that death occurred on the date and hour stated above.

Immediate cause of death Senility Duration 6 mos

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

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

23. Signature Lois C. Wyatt (M. D. or other) M.D.
Address 124 E. Union Date signed 3-6-47

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

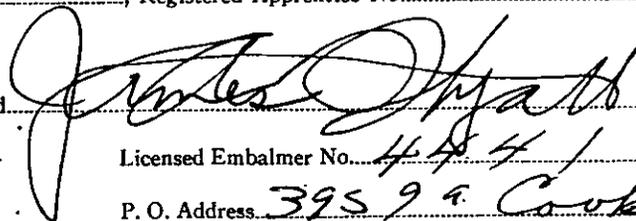
MOTHER FATHER

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


Licensed Embalmer No. 4441
P. O. Address 395 9th Cook

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.