

Registration District No. **199** Primary Registration District No. **1002**

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

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:
560 Stenwall Court
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 5 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 560 Stenwall Court
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MARTIN CLEMENT HAWK
 3. (b) If veteran, name war no 3. (c) Social Security No. 495-20-7227A

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 17TH
 year 1947 hour 8:30 minute P M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife MRS. SARAH HAWK 6. (c) Age of husband or wife if alive 70 years
 7. Birth date of deceased December 5, 1874
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 26
1947, to May 17, 1947.
 that I last saw him alive on May 16, 1947
 and that death occurred on the date and hour stated above.

8. AGE: Years 72 Months 5 Days 12
 If less than one day _____ hr. _____ min.

Immediate cause of death myocardial degeneration
 Due to Hypertension
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace Shelby County Illinois
 (City, town, or county) (State or foreign country)

Duration 2 weeks
 24 hrs?
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

10. Usual occupation retired

Major findings: Of operations _____
 Of autopsy _____
 22. If death was due to external causes, fill in the following:

MOTHER FATHER
 11. Industry or business _____
 12. Name PHILIP HAWK
 13. Birthplace Illinois
 (City, town, or county) (State or foreign country)
 14. Maiden name EMMA RICHMAN
 15. Birthplace OHIO
 (City, town, or county) (State or foreign country)

(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 _____

16. (a) Informant MRS. LOUIS MARKS
 (b) Address 608 E 74TH STREET
 17. (a) BURIAL (b) Date thereof MAY 20 1947
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation MEMORIAL PARK CEMETERY

23. Signature John M Powers (M. D. or other) MD
 Address 3304 Linwood Date signed 5/17/47

18. (a) Signature of funeral director J. H. Bukameris
 (b) Address 1401 N. Rush Creek Blvd
 19. (a) 5-20-47 (b) M. G. Holman
 (Date received local registrar) (Registrar's signature)

3327 Funeral Blvd.
1-5

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.....

John E. Praking
working under my personal supervision.

Registered Apprentice No. *504*

Signed *E. Oscar Horkley*

Licensed Embalmer No. *1767*

P. O. Address *Kansas City*

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.