

**FILED JUL 31 1947**  
Registration District No. **2**

Primary Registration District No. **5635**

Registrar's No. **100**

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

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Conway (Rural)  
(If outside city or town limits write "RURAL" and name of township)

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede

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

(d) Street No. 1  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN MARTIN HAWK

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7  
year 1947 hour 9 minute 30 A.M.

4. Sex MO 5. Color or race W

6. (a) Name of husband or wife Sarah Hawk

6. (b) Age of husband or wife if alive 66 years

7. Birth date of deceased March 8 1879  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 1947 to July 7, 1947  
that I last saw him alive on June 30, 1947  
and that death occurred on the date and hour stated above

Immediate cause of death Cardiac Failure  
Duration \_\_\_\_\_

8. AGE:

Years	Months	Days	If less than one day
<u>68</u>	<u>3</u>	<u>29</u>	hr. _____ min. _____

Due to Chronic Myocarditis

Due to \_\_\_\_\_

9. Birthplace Laclede Co. Mo.  
(City, town, or county) (State or foreign country)

Other conditions 93H  
(Include pregnancy within 3 months of death)

10. Usual occupation Farmer

11. Industry or business Farm

12. Name William Hawk

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

14. Maiden name Nancy Price

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

16. (a) Informant Mrs. Inez Justus (Daughter)

(b) Address Springfield Mo.

17. (a) Burial (b) Date thereof 7-9-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Conway Cemetery

18. (a) Signature of funeral director W.E. Holman

(b) Address Lebanon Mo.

19. (a) 7-26-1947 (b) Dr. Frankberger  
(Date received local registrar) (Registrar's signature)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? 1  
(Specify type of place)

While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature W. Saunders (M. D. or other) Dr.  
Address Lebanon, Mo. Date signed 7/9/47

PHYSICIAN

Underline the cause of which death should be charged statistically.

Received 7/30/47

Leede County Health Unit

No. 7-47-122

Date Filed 7/30/47

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon 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.