

3. No. 2  
-1/47  
5-17-39

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35818

FILED NOV 7 1947 318

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10023

1. PLACE OF DEATH:

(a) County: St. Louis Mo.  
(b) City or town: St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Wosp #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: \_\_\_\_\_ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: St. Louis  
(c) City or town: St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No.: 5500 Grand  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
Age, name country: 13

3. (a) PRINT FULL NAME: Henry F. Newkirk

3. (b) If veteran, name war: \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

5. Color: White  
6. (a) Single, widowed, married, divorced: unm.  
4. Sex: Male race: White  
6. (b) Name of husband or wife: \_\_\_\_\_ 6. (c) Age of husband or wife if alive: Wife - 18  
7. Birth date of deceased: \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: 11 Years 8 1/2 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: Waukegan, Iowa (City, town, or county) (State or foreign country)

10. Usual occupation: Cook

11. Industry or business: unm.

12. Name: unm.

13. Birthplace: Waukegan, Iowa (City, town, or county) (State or foreign country)

14. Maiden name: unm.

15. Birthplace: Waukegan, Iowa (City, town, or county) (State or foreign country)

16. (a) Informant: W. R. [unclear]

(b) Address: 300 Clark

17. (a) Anatomical Board Date thereof: 10-17-47 (Burial, cremation, or removal) (City) (Day) (Year)  
(c) Place: burial or cremation: Wahington

18. (a) Signature of funeral director: W. R. [unclear]

(b) Address: 300 Clark

19. (a) OCT 30 1947 (Date received local registrar) (b) J. F. [unclear] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1947 month Sept day 8 year \_\_\_\_\_ hour 53 minute \_\_\_\_\_

21. I hereby certify that I attended the deceased from 1947 to 1947 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death: \_\_\_\_\_

Due to: Secondary pneumonia

Due to: Wosp.

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: 108

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? \_\_\_\_\_ (Specify type of place)

While at work? \_\_\_\_\_ (c) Means of injury: \_\_\_\_\_

23. Signature: [unclear] (M.D. or other) \_\_\_\_\_

Address: \_\_\_\_\_ Date signed: 10/9/47

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

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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 Howard J Rowland  
Licensed Embalmer No. 3114  
P. O. Address W. T. Lane 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. Nov.Registration District No. 318Primary Registration District No. 1003Registrar's No. 10023

## 1. PLACE OF DEATH:

- (a) County.....  
 (b) City or town..... St. Louis  
 (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.....  
years, months or days)3. (a) PRINT  
FULL NAMEHenry J. Hawkins

3. (b) If veteran,
- 
- name war.....

3. (c) Social Security
- 
- No.....

## 4. Sex

m5. Color or  
race W

6. (a) Single, widowed, married,
- 
- divorced
- and

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if
- 
- alive.....

7. Birth date of deceased.....

(Month)

(Day)

(Year)

## 8. AGE:

off 84

Years

Months

Days

(If less than one day

hr. min.

9. Birthplace.....

(City, town, or county)

(State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

(City, town, or county)

(State or foreign country)

14. Maiden name.....

15. Birthplace.....

(City, town, or county)

(State or foreign country)

16. (a) Informant.....

- (b) Address.....

17. (a).....

(Burial, cremation, or removal)

- (b) Date thereof.....

(Month) (Day) (Year)

- (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

- (b) Address.....

19. (a).....

(Date received local registrar)

- (b)
- NOV 19 1947

NOV 19 1947

(Date received local registrar)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....  
 (c) City or town.....  
 (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.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....
- 
- year.....
- 1947
- hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
- 
- to....., 19.....;
- 
- that I last saw him..... alive on....., 19.....;
- 
- and that death occurred on the date and hour stated above.
- 
- Immediate cause of death.....

Duration

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 sta-  
tistically.

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..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

S-35818