

No. 300  
10-47  
5-17-39  
1906

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **29796**  
Registrar's No. **3819**

FILED SEP 25 1948

Registration District No. **149**

Primary Registration District No. **100.2**

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:  
General Hospital #1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 minutes  
(Specify whether years, months or days)

In this community 3 1/2 months

3: (a) PRINT FULL NAME EMMA JANE HAWKINS

3: (b) If veteran, name war No

3: (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

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

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

7. Birth date of deceased May 14 1860  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
88	4	3	hr. min.

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

10. Usual occupation Home

11. Industry or business X

12. Name Levi Flowers

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

14. Maiden name Kitty Ann Stevenson

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

16. (a) Informant Mrs. Laura Hedrick

(b) Address 3117 Harrison K. C. Mo

17. (a) Burial  
(Burial, cremation, or removal)

(b) Date thereof Sept 19 1948  
(Month) (Day) (Year)

(c) Place: burial or cremation Keytesville, Missouri

18. (a) Signature of funeral director Harrison Garnett Funeral Home

(b) Address Keytesville, Missouri

19. (a) 9-17-48  
(Date received local registrar)

(b) Sheraldine Holmes  
(Registrar's signature)

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. 3117 Harrison  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 17  
year 1948 hour 11:25 minute 0 M.

21. I hereby certify that I attended the deceased from Person, 19  , to   , 19  ;  
that I last saw h.    alive on   , 19  ;  
and that death occurred on the date and hour stated above.

Immediate cause of death   

Due to   

Due to   

Other conditions     
(Include pregnancy within 3 months of death)

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?   

23. Signature    (M. D. or other)   

Address    Date signed 9-17-48

23. Signature    (M. D. or other)   

Address    Date signed 9-17-48

23. Signature    (M. D. or other)   

Address    Date signed 9-17-48

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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 Chas E. Wilks

Licensed Embalmer No. 2644

P. O. Address 110 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.**

FILED JAN 8 1949  
149

Registration District No. ....

Primary Registration District No. 1002

Registrar's No. 3819

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... *Kansas City*  
(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 NAME

*Emma Jane Hawkins*

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

(c) Social Security No.....

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

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: 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) *9-17-48* (Date received local registrar) (b) *Steldine Holmes* (Registrar's signature)

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..... hour..... minute..... M.

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

Duration

*sodium fluoroide*  
Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 5 months of death)

Major findings:  
Of operations.....

PHYSICIAN

Of autopsy..... *yes*

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) *suicide*  
(b) Date of occurrence *9-17-48*  
(c) Where did injury occur? *J. C. Jackson, Mo.*  
(City or town) (County) (State)  
(d) Did injury occur in or about home, or farm, or industrial place, in public place?  
*at home*

While at work? *no* (Specify type of place) (e) Means of injury *poison*

23. Signature *James C. Walker* (M. D. or other).....

Address *1424 Prof. Bldg.* Date signed.....

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

SUPPLEMENTARY

S-29796 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29796  
Registrar's No. 3819

Registration District No. 149 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:  
 (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) (Specify whether

**3. (a) PRINT FULL NAME** Emma Jane Hurlbiss  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased may 14 (Month) (Day) (Year)

8. AGE: Years 88 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

**MOTHER** { 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
 (Burial, cremation, or removal)  
 (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

**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 \_\_\_\_\_ Day \_\_\_\_\_ Year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw \_\_\_\_\_ 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)

**PHYSICIAN**

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_ 13B

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 J. M. ... (M. D. or other) \_\_\_\_\_  
 Address 1429 ... Date signed \_\_\_\_\_

**SUPPLEMENTARY**

*Handwritten signature or scribble, possibly containing the name "W. H. ..."*

S-29796 1948