

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34225**
9590

National Office of Vital Statistics

FILED NOV 12 1948

Registration District No. **318** Primary Registration District No. **7000**

Registrar's No. **179**

1. PLACE OF DEATH:
(a) Country: **St. Louis, Mo.**
(b) City or town: **St. Louis, Mo.**
(If outside city or town limits, give "RURAL" and name of township)
(c) Name of hospital or institution: **4191 Ewright**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: **About 25 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: **Mo** (b) County: **own 17**
(c) City or town: **St. Louis Mo** (If outside city or town limits, write "RURAL")
(d) Street No: **4191 Ewright** (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: **Bettie Hawkins**
3. (b) If veteran, name war: **No** 3. (c) Social Security No.: **No**
4. Sex: **Female** 4. (a) Single, widowed, married, divorced, **Widower**
5. race: **Colored** 6. (c) Age of husband or wife if alive: **years**
6. (b) Name of husband or wife: **years**
7. Birth date of deceased: **Feb. 28** (Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month: **Oct 29** day: **29** year: **1948** hour: **1** minute: **30 P.M.**
21. I hereby certify that I attended the deceased from **Oct 28** 19**48** to **Oct 29** 19**48** that I last saw her alive on **Oct 29** 19**48** and that death occurred on the date and hour stated above.

8. AGE: Years: **About 60** Months: Days: If less than one day: hr. min.
9. Birthplace: **Lexington, Miss.** (City, town, or county) (State or foreign country)
10. Usual occupation: **Housekeeper**
11. Industry or business: **Jacob Bennett**
12. Name: **Lexington Miss.**
13. Birthplace: **Lexington Miss.** (City, town, or county) (State or foreign country)
14. Maiden name: **Elizabeth ?**
15. Birthplace: **Lexington, Miss.** (City, town, or county) (State or foreign country)
16. (a) Informant: **4191 Ewright Ave.** (b) Address:
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof: **11-4-48** (Month) (Day) (Year)
(c) Place: burial or cremation: **Washington Park**
18. (a) Signature of funeral director: **A. L. Beal U M Co.** (b) Address: **2726 Incas Ave.**
19. (a) **NOV 4 1948** (Date received local registration) (b) **J. B. Laster** (Registrar's signature)

Immediate cause of death: **Cerebral Neurotosis 1 day**
Due to: **Arterio Sclerosis umbra**
Due to: **Hypertension**
Other conditions: **8/3** (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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: **J. E. Moore** (M. D. or other)
Address: **809 N Jefferson** Date signed: **11-3-48**

Duration
PHYSICIAN
Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

me
3655
2011

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

Herbert J. Hancock

Licensed Embalmer No. 4243

P. O. Address 17 Waymire St

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.