

FILED JAN 12 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40478**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 55 PRIMARY REG. DIST. NO. 3011 Registrar's No. 114

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Carroll</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Carrollton</b> ( )		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Carrollton R.F.D. # 1.</b>	
c. LENGTH OF STAY (In this place) <b>Month</b>		d. STREET ADDRESS (If rural, give location) <b>Carrollton Mo.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Staton Clinic</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Emma</b>	b. (Middle) <b>Frances</b>	c. (Last) <b>Hawkins</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 16 1949</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Feb 25, 1861</b>	9. AGE (In years last birthday) <b>88</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>21</b>	IF UNDER 24 Hrs. Hour <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>House Wife</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Addison Harper</b>	13b. MOTHER'S MAIDEN NAME <b>Susan Cottrell</b>	14. NAME OF HUSBAND OR WIFE <b>Lewis Hawkins</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Harper Hawkins</b>	ADDRESS <b>Carrollton RFD #1</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Mitral Insufficiency</b>		<b>2 yrs?</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Atteration of the muscular fibres of the heart?</b> DUE TO (c) <b>old Age</b>		<b>410A</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Nov. 19, 1949**, to **Dec. 16, 1949**, that I last saw the deceased alive on **Dec. 16, 1949** and that death occurred at **10:00 a.m.**, from the causes and on the date stated above.

SIGNATURE <b>Dr. Hamilton Staton, M.D.</b> (Degree or title)	23b. ADDRESS <b>Carrollton Mo.</b>	23c. DATE SIGNED <b>Dec 17 1949</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Dec. 18, 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Antioch Cemetery</b>	24d. LOCATION (City, town, or county) <b>North of Norborne Mo.</b>
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DATE REC'D BY LOCAL REG. <b>12/16/49</b>	REGISTRAR'S SIGNATURE <b>Mr. Herbert Calvert</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall Funeral Home</b>	ADDRESS <b>Carrollton Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED JAN 4

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 1-11-50

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed P. M. Marshall Jr

Licensed Embalmer No. 4469

P. O. Address Carrollton Ga

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.