

FILED FEB 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5546

BIRTH NO. _____ REG. DIST. NO. 243 PRIMARY REG. DIST. NO. 4364 Registrar's No. 4

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Newton</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>McDonald</u> | |
| b. CITY OR TOWN <u>Stella</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Anderson - Rural</u> | |
| c. LENGTH OF STAY (in this place) <u>3 weeks</u> | | d. STREET ADDRESS (If rural, give location) <u>0600</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Cardwell</u> | | | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Peter</u> b. (Middle) <u>OSTON</u> c. (Last) <u>Hawk</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 26-50</u> | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | |
| 8. DATE OF BIRTH <u>Sept. 4-1875</u> | | 9. AGE (In years last birthday) <u>74</u> | | 10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>23</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |

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|--|--|--|--|---|--|
| 13a. FATHER'S NAME <u>Geo. W. Hawk</u> | | 13b. MOTHER'S MAIDEN NAME <u>Salana Hudson</u> | | 14. NAME OF HUSBAND OR WIFE <u>Sena B. Hawk</u> | |
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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) <u>no.</u> | | 16. SOCIAL SECURITY NO. <u>no.</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Sena B. Hawk-Anderson</u> | |
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Mycocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | <u>4222</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from 1-1, 1950, to 1-26, 1950, that I last saw the deceased alive on 1-26, 1950, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

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|--|--|-------------------------------|--|---------------------------------|--|
| 23a. SIGNATURE <u>C. Cardwell M.D.</u> | | 23b. ADDRESS <u>Stella Mo</u> | | 23c. DATE SIGNED <u>1-26-50</u> | |
|--|--|-------------------------------|--|---------------------------------|--|

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|---|--|----------------------------|--|--|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE <u>Jan 31-50</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Anderson</u> | | 24d. LOCATION (City, town, or county) (State) <u>Anderson Mo</u> | |
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|---|--|--|--|---|--|
| DATE REC'D BY LOCAL REG. <u>Feb-17 1950</u> | | REGISTRAR'S SIGNATURE <u>Alpha Dizer 369</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wheaton Funeral Home Wheaton Mo</u> | |
|---|--|--|--|---|--|

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

RECEIVED

District Health Officer No. _____

Newton Co. Health Dept.

District File Number _____

250-76

Date Filed _____

Feb 20 1950

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.

Signed _____

Paul D. Herbert

Signed _____

Student Embalmer

Licensed Embalmer No. _____

4576

P. O. Address _____

Cassville 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.