

FILED JAN 13 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42348**
11010

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **10** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 25 yrs		2189	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3230 LaSalle St		d. STREET ADDRESS (If rural, give location) 3230 LaSalle St.	

3. NAME OF DECEASED (Type or Print) a. (First) Johnny	b. (Middle)	c. (Last) Hawkins	4. DATE OF DEATH (Month) (Day) (Year) Dec, 24, 1950
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5. SEX Female 3	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb, 1, 1886	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months 10	IF UNDER 1 HR. Days 22	IF UNDER 1 HR. Hours 22	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Water Valley, Miss.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Somman Mo Donald	13b. MOTHER'S MAIDEN NAME Mary ?	14. NAME OF HUSBAND OR WIFE R. Hawkins
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME R. Hawkins 3230 LaSalle St.	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>		Un Known
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c)		
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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 322X
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22. I hereby certify that I attended the deceased from Dec 4, 1950, to Dec, 24, 1950; that I last saw the deceased alive on 12-23, 1950, and that death occurred at 3:30 A m., from the causes and on the date stated above.

23a. SIGNATURE <u>D. J. Smith, M.D.</u>	(Degree or title)	23b. ADDRESS <u>11 N. Jefferson</u>	23c. DATE SIGNED <u>12-24-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/29/50.	24c. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Co. Mo.
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DATE REC'D BY LOCAL REG. DEC 26 1950	REGISTRAR'S SIGNATURE <u>D. B. Luster</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wright Funeral Home. 3100 Easton Ave.</u>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Arthur L. Hollard

Licensed Embalmer No. 4221

P. O. Address 4049 St Ferdinand

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.