

No. 300
10-1-58

FILED MAY 12 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15140

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 969

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Manchester</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>2199</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Manchester Nursing Home.</u>		d. STREET ADDRESS (If rural, give location) <u>4471 Olive St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Leslie</u> b. (Middle) <u>F.</u> c. (Last) <u>Hawkins</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 12, 1951</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>Aug. 6, 1880</u>		9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Linotype Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Little Rock, Ark.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					

13a. FATHER'S NAME <u>John Hawkins</u>		13b. MOTHER'S MAIDEN NAME <u>Lelia Files</u>		14. NAME OF HUSBAND OR WIFE <u>May A. Hawkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>es Sp. Am.</u>		16. SOCIAL SECURITY NO. <u>489-07-7189</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. May Hawkins, 4471 Olive St.</u>	

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>St. hemiplegia</u>			INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Hypertensive heart disease</u>				
		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"/>	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Apr. 6, 1951, to Apr. 12, 1951, that I last saw the deceased alive on Apr. 11, 1951, and that death occurred at 9:45 p. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Dr. Denny M.D.</u> (Degree or title)		23b. ADDRESS <u>Creve Coeur Mo</u>		23c. DATE SIGNED <u>4-13-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>4-13-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Rose Lawn</u>	
				24d. LOCATION (City, town, or county) (State) <u>Little Rock, Ark.</u>	

DATE REC'D BY LOCAL REG. <u>4/13/51</u>		REGISTRAR'S SIGNATURE <u>Herbert P. Lomke M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd.</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

John W. Brubaker
12 21 50

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 _____

J. W. Brubaker
Licensed Embalmer No. *3653*

P. O. Address _____

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.