

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29616

FILED SEP 9 - 1953

State File No. _____

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BIRTH NO. _____		REG. DIST. NO. <u>290</u>		PRIMARY REG. DIST. NO. <u>4427</u>		Registrar's No. <u>99</u>			
1. PLACE OF DEATH a. COUNTY <u>Polk</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Phelps</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>Waynesville</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rolla</u>		0819			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Waynesville General Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>R # 2</u>					
3. NAME OF DECEASED (Type or Print) <u>WILLIE MAE HAWKS</u>			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH (Month) (Day) (Year) <u>8 29 53</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 10 1914</u>	
9. AGE (in years last birthday) <u>39</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Quail Tex.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>William Chair</u>			13b. MOTHER'S MAIDEN NAME <u>Alice Velma Foshee</u>			14. NAME OF HUSBAND OR WIFE <u>Marion V. Hawks</u>			
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.		17. INFORMANT'S SIGNATURE OR NAME <u>Marion V. Hawks</u>				ADDRESS <u>Rolla Mo. # 2</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>Generalized Peritonitis</u> ANTECEDENT CAUSES DUE TO (b) <u>Obstruction of Descending Colon</u> DUE TO (c) <u>Major Surgery</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 days</u> <u>8/21/53</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Be. Lateral Ovarian Pipts</u>						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) 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 <u>8/20</u> , 1953, to <u>8/29</u> , 1953, that I last saw the deceased alive on <u>8/29</u> , 1953, and that death occurred at <u>7:40</u> Am., from the causes and on the date stated above.									
23a. SIGNATURE <u>R. P. Dewitt</u>				(Degree or title)		23b. ADDRESS <u>Waynesville Mo.</u>		23c. DATE SIGNED <u>8/29/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 1-1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Newburg Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Newburg Mo.</u>			
DATE REC'D BY LOCAL REG. <u>9-1-53</u>		REGISTRAR'S SIGNATURE <u>Paul M. Anderson</u>		458 0		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Johnson</u>		ADDRESS <u>Newburg Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

Date Filed 9-5-53
File Number _____
Public Health Officer _____

RECEIVED
9-1-53

MAR 3 1956

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 Lee Johnson
Licensed Embalmer No. 3392

P. O. Address Newburg 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.