

FILED NOV 19 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39834

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 166

1. PLACE OF DEATH a. COUNTY <u>Scott</u>			2. USUAL RESIDENCE (Where deceased lived... If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u>		c. LENGTH OF STAY (in this place) <u>2 Days</u>	c. CITY OR TOWN <u>Sikeston</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hospital</u>			e. STREET ADDRESS (If rural, give location) <u>416 Wilson</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u> b. (Middle) <u>Franklin</u> c. (Last) <u>Hawkins</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>11 5 1954</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>12-18-1883</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months Days	IF UNDER 48 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Hawkins</u>		13b. MOTHER'S MAIDEN NAME <u>May Wright</u>		14. NAME OF HUSBAND OR WIFE <u>Emma Ratley</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>0</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Jessie Taylor, Sikeston, Mo.</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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) <u>Arteriosclerotic Cardiovascular disease with myocardial infarction</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>infarction</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4201</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	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>11-1</u> , 19 <u>54</u> , to <u>11-5</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>11-5</u> , 19 <u>54</u> , and that death occurred at <u>1:00 P. m.</u> , from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) <u>Alden B. Sargent M.D.</u>			23b. ADDRESS <u>Sikeston, Missouri</u>		23c. DATE SIGNED <u>11-7-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>11-7-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>GARDEN OF MEMORIES</u>		24d. LOCATION (City, town, or county) (State) <u>SIKESTON MO</u>		
DATE REC'D BY LOCAL REG. <u>11-12-54</u>	REGISTRAR'S SIGNATURE <u>Mrs. Clara Henschel</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Weld Funeral Home Sikeston Mo.</u>			

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

DATE RECEIVED NOV 15 1954

SCOTT CO. HEALTH DEPT.

CO. FILE No. 1154-235

NOV 15 1954

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.....
Signature of Student Embalmer

Signed Raymond Grews

Licensed Embalmer No. 346

P. O. Address Leicester

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.