

FILED DEC 17 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42441
State File No. 11217
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 4135 Fairfax	

3. NAME OF DECEASED (Type or Print)	a. (First) Minnie	b. (Middle) R.	c. (Last) Hawkins	4. DATE OF DEATH (Month) (Day) (Year)
				12 8 54

5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 15, 1892	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months 3 Days 23	IF UNDER 24 HRS. Hours 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 (City and State or Foreign Country) Mason, Tenn.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Mack Dugger	13b. MOTHER'S MAIDEN NAME Donnie Baptist	14. NAME OF HUSBAND OR WIFE James Hawkins
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME	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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undt.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma of Colon with Cerebral Metastases		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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? 153x
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22. I hereby certify that I attended the deceased from **12-5**, 19**54**, to **12-8**, 19**54**, that I last saw the deceased alive on **12-8**, 19**54**, and that death occurred at **10:10 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edw. B. Williams M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 12-9-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removed	24b. DATE Dec. 13, 1954	24c. NAME OF CEMETERY Oak Dale	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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DATE REC'D BY LOCAL DEC 9 1954	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE J.H. RANDLE & SON	ADDRESS 3133 Bell Ave.
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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.....
Signature of Student Embalmer

Signed *S J Station*.....

Licensed Embalmer No. *269*.....

P. O. Address *2749th*.....

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.