

STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 36 PRIMARY REG. DIST. NO. 4531

1. PLACE OF DEATH
a. COUNTY Warren
b. CITY OR TOWN Warrenton
c. LENGTH OF STAY (in this place) 6 months
d. FULL NAME OF HOSPITAL OR INSTITUTION Katie Jane Memorial Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN St. Ann's 4071
d. STREET ADDRESS 51 St. Mary's Lane

3. NAME OF DECEASED
a. (First) Bertha b. (Middle) Jane (Jean) c. (Last) Hawks
4. DATE OF DEATH (Month) (Day) (Year) Dec. 26, 1954

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 2
8. DATE OF BIRTH Dec. 14, 1883 9. AGE (In years last birthday) 71 10. MONTHS 0 11. DAYS 12

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Calvin Kirk
13b. MOTHER'S MAIDEN NAME Aliza Green
14. NAME OF HUSBAND OR WIFE Andrew Hawks, deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME Mrs. Carl Lasher ADDRESS 51 St. Mary's Lane St. Ann's, Mo.

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.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia bilateral hypostatic
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis
DUE TO (c) arteriosclerosis
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Cerebral vascular disease
INTERVAL BETWEEN ONSET AND DEATH 2 days
White

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES NO

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) (Minute)
21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-26, 1954, to 12-26, 1954, that I last saw the deceased alive on 12-24, 1954, and that death occurred at 6:10 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)
23b. ADDRESS
23c. DATE SIGNED 12-27-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-29-54
24c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

DATE REC'D BY LOCAL REG 12-28-54 REGISTRAR'S SIGNATURE Lloyd Logan 421-20
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hy. Leidner Und. Co. St. Louis, Mo.

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

90
4

3361 28 NOV 1955

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed

John Z. Kieburg

Licensed Embalmer No. *3897*

P. O. Address *Warrenton, 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.