

FILED MAR 5 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5368

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 3028 Registrar's No. 47

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Jasper                       |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri b. COUNTY Greene |  |
| b. CITY OR TOWN Carthage                                    |  | c. CITY OR TOWN Springfield  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION McCune Brooks Hosp. |  | e. STREET ADDRESS (If rural, give location) 1142 S. Kentwood 0376  |  |

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|--|--|--|--|--|--|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) Paul b. (Middle) H c. (Last) Hawkins |  |  | 4. DATE OF DEATH (Month) (Day) (Year) Feb. 18-1956 |  |  |
|--|--|--|--|--|--|

|   |  |                        |  |  |  |                                |  |  |  |                             |  |                                     |  |  |  |
|---|--|------------------------|--|--|--|--------------------------------|--|--|--|-----------------------------|--|-------------------------------------|--|--|--|
| 5. SEX Male   |  | 6. COLOR OR RACE White |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married |  | 8. DATE OF BIRTH June 22, 1911 |  | 9. AGE (In years last birthday) 42                     |  | IF UNDER 1 YEAR Months Days |  | IF UNDER 24 HRS. Hours Min.         |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life; give if retired) LUMBER Co |  |                        |  | 10b. KIND OF BUSINESS OR INDUSTRY MANAGER                      |  |                                |  | 11. BIRTHPLACE (City and State or Foreign Country) MO. |  |                             |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |  |  |  |

|                            |  |  |                                   |  |  |  |  |  |  |  |  |
|----------------------------|--|--|-----------------------------------|--|--|--|--|--|--|--|--|
| 13a. FATHER'S NAME UNKNOWN |  |  | 13b. MOTHER'S MAIDEN NAME UNKNOWN |  |  | 14. NAME OF HUSBAND OR WIFE RACHEL HAWKINS |  |  |  |  |  |
|----------------------------|--|--|-----------------------------------|--|--|--|--|--|--|--|--|

|   |  |                              |  |   |  |  |  |  |  |  |  |
|---|--|------------------------------|--|---|--|--|--|--|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN |  | 16. SOCIAL SECURITY NO. YES. |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS RACHEL HAWKINS SPRINGFIELD, MO. |  |  |  |  |  |  |  |
|---|--|------------------------------|--|---|--|--|--|--|--|--|--|

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|---|--|---|--|--|--|--|--|--|--|--|--|--------------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphatic Leukemia<br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH 18M |  |
|---|--|---|--|--|--|--|--|--|--|--|--|--------------------------------------|--|

|                        |  |                                       |  |  |  |  |  |   |  |
|------------------------|--|---------------------------------------|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION |  | 19b. MAJOR FINDINGS OF OPERATION 2040 |  |  |  |  |  | 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 Jan 11, 1955, to Feb 18, 1956, that I last saw the deceased alive on Feb 18, 1956, and that death occurred at 11 P. m., from the causes and on the date stated above.

|                               |  |                        |  |                           |  |                            |  |
|-------------------------------|--|------------------------|--|---------------------------|--|----------------------------|--|
| 23a. SIGNATURE Karl H. Birmer |  | (Degree or title) M.D. |  | 23b. ADDRESS Carthage, Mo |  | 23c. DATE SIGNED Feb 19-56 |  |
|-------------------------------|--|------------------------|--|---------------------------|--|----------------------------|--|

|   |  |                   |  |                                    |  |  |  |
|---|--|-------------------|--|------------------------------------|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL |  | 24b. DATE 2-19-56 |  | 24c. NAME OF CEMETERY OR CREMATORY |  | 24d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO. |  |
|---|--|-------------------|--|------------------------------------|--|--|--|

|                                  |  |                                   |  |     |  |  |  |
|----------------------------------|--|-----------------------------------|--|-----|--|--|--|
| DATE REC'D BY LOCAL REG. 2-19-56 |  | REGISTRAR'S SIGNATURE [Signature] |  | 139 |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS [Signature] Springfield, Mo |  |
|----------------------------------|--|-----------------------------------|--|-----|--|--|--|

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

RECEIVED MAR 2 1956  
Jasper County Health Office

County File Number: 56-3-192  
Date Filed: MAR 2 1956

MAR 5 1956

MAR 28 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.....  
Signature of Student Embalmer

Signed.....  
*[Handwritten Signature]*

Licensed Embalmer No. 331  
11478 Glenston  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.