

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 24 1956

BIRTH NO. **85335-56** REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1341**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) St. Joseph Mo	c. LENGTH OF STAY (In this place) the 40m	c. CITY OR TOWN St. Joseph Mo	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		e. STREET ADDRESS (If rural give location) 2818 Mulberry St.	

3. NAME OF DECEASED (Type or Print) Mary Lynn Hawkins	4. DATE OF DEATH (Month) (Day) (Year) Dec 18 1956
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Never	8. DATE OF BIRTH Dec 17 - 1956	9. AGE (In years last birthday) # UNDER 1 YEAR Months Days 17 140
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 0	10b. KIND OF BUSINESS OR INDUSTRY 0	11. BIRTHPLACE (City and State or Foreign Country) St. Joseph Mo.	12. CITIZEN OF WHAT COUNTRY? 0
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13a. FATHER'S NAME James Benjamin Hawkins	13b. MOTHER'S MAIDEN NAME Phyllis Jean Orminger	14. NAME OF HUSBAND OR WIFE 0
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 0	16. SOCIAL SECURITY NO. 0	17. INFORMANT'S SIGNATURE OR NAME Phyllis Hawkins	ADDRESS 2818 Mulberry City
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity wgt 3-9		INTERVAL BETWEEN ONSET AND DEATH 18 hrs
	ANTECEDENT CAUSES DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (c) 0		
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 776 X	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) St. Joseph Buch. Mo
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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? 0
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22. I hereby certify that I attended the deceased from **12-17, 1956**, to **12-17, 1956**, that I last saw the deceased alive on **12-17-56**, and that death occurred at **3:07m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. E. Plummer MD	23b. ADDRESS St. Joseph Mo	23c. DATE SIGNED 12-18-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/18/1956	24c. NAME OF CEMETERY OR CREMATORY Hillmore Cemetery	24d. LOCATION (City, town, or county) (State) Hillmore Mo.
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DATE REC'D BY LOCAL REG. Dec. 20, 1956	REGISTRAR'S SIGNATURE Ethel M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE Heaton Bowman	ADDRESS St. Joseph Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2221
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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..... Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319th St. H. J. M.

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.