

Health, Welfare, Public Service
 300
 1-56
 Director, coroner, etc. must use only standard nomenclature in their reports. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

2495

FILED JAN 29 1957

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 4461 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bismarck</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Bismarck</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>			Length of stay in lb <u>14 Yrs.</u>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PHILLIP</u> Middle <u>RUSSELL</u> Last <u>HAWKINS</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>21</u> Year <u>1957</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 25, 1977</u>		9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.R. Engineer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (City and state or country) <u>Fredricktown, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Martin Hawkins</u>				14. MOTHER'S MAIDEN NAME <u>Cornelia Russell</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>708-16-5065</u>	17. INFORMANT Address <u>Anna Gertrude Hawkins Bismarck, Mo.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Circulatory Failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) <u>Coronary thrombosis, old and new</u> <u>2 years</u>	
DUE TO (c) <u>Chronic Myocardial Insufficiency</u> <u>Years</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>								
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Bismarck, Missouri</u>		COUNTY <u></u> STATE <u></u>		
21. I attended the deceased from <u>April 11, 1955</u> to <u>Jan. 21, 1957</u> and last saw ^{him} alive on <u>Jan. 21, 1957</u> Death occurred at <u>1:55 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>R. A. Mendigate D.O.</u>				22b. ADDRESS <u>Bismarck, Missouri</u>		22c. DATE SIGNED <u>1-22-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-24-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Bismarck, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Shipman & Sons Bismarck, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Jan. 23, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>			

JAN 30 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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John N. Shipman*

Licensed Embalmer No. 488

P. O. Address Bismarck, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.