

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **10383**
2404
Registrar's No.

FILED APR 12 1957
Registration District No. **318** Primary Registration District **1003**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Ark.		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Paragould, Ark		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 106 N. 7th St.,		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Dr. Charles R. Hawker			4. DATE OF DEATH March 10, 1957		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 3, 1881	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Physician (10 yrs)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Illinois /		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Hawker			14. MOTHER'S MAIDEN NAME Sarah Ross		
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. unk	17. INFORMANT Address Dr. W. D. Hawker 4096 Holly Hills		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis					INTERVAL BETWEEN ONSET AND DEATH one week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) Arteriosclerotic Heart Disease one year
					DUE TO (c) Generalized arteriosclerosis one year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 Month, Day, Year a. m. p. m.					
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	COUNTY	STATE
21. I attended the deceased from Jan. 3, 1957 to March 10, 1957 and last saw DEAD live on 3-10-57 Death occurred at 158 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE James R. Murphy, M.D.			22b. ADDRESS 634 North Grand Blvd.		22c. DATE SIGNED 3-11-57
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 3-13-57	23c. NAME OF CEMETERY OR CREMATORY Parklawn	23d. LOCATION (City, town, or county) (State) Lemay 23, Mo.	
24. FUNERAL DIRECTOR Southern Funeral Home 6322 S. Grand, St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. MAR 11 '57	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. M. J. B.		

Health, & Welfare Public Service

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Doctor, coroner, etc. must use only standard nomenclature in item 18. 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

Securing the medical certification in this specific manner is required by law.

Dr. James Murphy
University Club Bldg.
1030 to 12 into 4

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by Student Embalmer No.

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Samuel H. ...*

Licensed Embalmer No. *42*

P. O. Address *St. Louis*

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