

FILED FEB 24 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-004519  
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 155

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>St. Joseph</b> <i>0117</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>309 Robidoux St.</b>		d. STREET ADDRESS (If outside, give location) <b>309 Robidoux St.</b>	
Length of stay in lb <b>30 Years</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>MAGNOLIA</b> Middle <b>ISABELLE</b> Last <b>HAWN</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>10</b> Year <b>1958</b>		
--	--	--	--	--	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1862</b>	9. AGE (In years last birthday) <b>95</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
----------------------	-------------------------------	---	---------------------------------------	---	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Eords Ferry Tenn.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
--	---	---	---

13a. FATHER'S NAME <b>Payne Hickman</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Jane Underwood</b>	14. NAME OF HUSBAND OR WIFE <b>John Hawn (Deceased)</b>
---	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Blanche Eunice Hawn, St. Joseph, Mo.</b>	Address
---	-------------------------------------	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Cerebral Hemorrhages</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		
DUE TO (c) _____		<b>Unk.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 <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 6/7/57 to 2/10/58 and last saw her alive on 2/9/58  
Death occurred at 6:30A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>St. Mearney M D</i>	22b. ADDRESS <b>Social Welfare Board 10th &amp; Olive, St. Joseph, Mo.</b>	22c. DATE SIGNED <b>2/11/58</b>
--	--	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb. 12, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph Missouri</b>
---	--------------------------------	---	--

24. FUNERAL DIRECTOR <b>Stamey Funeral Home</b>	ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Feb 17, 1958</b>	26. REGISTRAR'S SIGNATURE <b>Ms. Clark Standell</b>
---	--------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms writ be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Charles E. Bennett

Licensed Embalmer No. 4677  
P. O. Address St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.