Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003034
STATE FILE NUMBER

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 676

FILED FEB 4 1959

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 4538 Page — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN St Louis 2129 — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 4538 Page — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: MARY HAWKINS
4. DATE OF DEATH Month 1 Day 17 Year 59
5. SEX F 3
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ 2 DIVORCED ☐
8. DATE OF BIRTH 6-10 1878
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months 7 Days 7 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Chesterfield
12. CITIZEN OF WHAT COUNTRY? MISSOUR
13a. FATHER'S NAME LOUIS CARTER
13b. MOTHER'S MAIDEN NAME SARAH HAMILTON
14. NAME OF HUSBAND OR WIFE WM HAWKINS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Lillie Johnson — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHO - PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH 1-13-59
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 491X
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 ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 1-13-59, to 1-17-59 and last saw her/him alive on 1-17-59
Death occurred at 8 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature]
22b. ADDRESS 822 a N. JEFFERSON
22c. DATE SIGNED 1-19-59

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE 1-22-59
23c. NAME OF CEMETERY OR CREMATORY GreenWood Cem
23d. LOCATION (City, town, or county) St. Louis Co. (State) MO.

24. FUNERAL DIRECTOR A.F. WALTON — ADDRESS 2707 Stoddard
25. DATE RECD. BY LOCAL REG. JAN 20 '59
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 .....

Licensed Embalmer No. 3489

P. O. Address 4575 Ala

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.