

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006473
STATE FILE NUMBER

FILED MAR 2 1959

Registration District No. 241 Primary Registration District No. 4360 Registrar's No. 8

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| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>New Madrid</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Portageville</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Portageville</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7th & Baker</u> | | Length of stay in 1b <u>9 years</u> | d. STREET ADDRESS (If outside, give location) <u>7th. & Baker</u> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Elizabeth Hawkins</u> | | | 4. DATE OF DEATH Month Day Year <u>Feb. 14 1959</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 1 1866</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>93</u> Months <u>1</u> Days <u>12</u> Hours <u></u> Min. <u></u> |
| 11. BIRTHPLACE (City and state or country) <u>Paris, Tennessee</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>John Webb</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary Newhouse</u> | 14. NAME OF HUSBAND OR WIFE |
| 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>None</u> | 17. INFORMANT Address <u>Mrs. Pearl Wilson, Portageville, 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>Chronic Arteriosclerotic Hypertensive Heart Disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senility.</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>143x</u> | |
| 20c. TIME OF INJURY Hour _____ 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 <u>July 1957</u> to <u>February 1959</u> and last saw her alive on <u>7 February 1959</u> Death occurred at <u>6 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>Andrew P. Painter M.D.</u> | | 22b. ADDRESS <u>223 King St., Portageville, Mo.</u> | 22c. DATE SIGNED <u>17 Feb 59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>2-16-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mounds Park</u> | 23d. LOCATION (City, town, or county) (State) <u>Near Lilbourn, Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Ponder Funeral Home-Lilbourn, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>2-21-59</u> | 26. REGISTRAR'S SIGNATURE <u>Ellen M. Lisle Wilson</u> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms or signs of disease in Part I must be causally related.

MAR 5 1959

VS MAR 2 1959

HEALTH DEPARTMENT
STATE OF MISSISSIPPI
HEALTH CENTER

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 D. Ponder*

Licensed Embalmer No. *5030*

P. O. Address *Silberman, Ark*

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.