

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008894

STATE FILE NUMBER

FILED MAR 27 1959

Registration District No. 99 Primary Registration District No. \_\_\_\_\_ Registrar's No. 11

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>DeKalb</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>DeKalb</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Stewartsville R#1</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Stewartsville R#1</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS <u>6 miles N.E.</u> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Lee</u> Last <u>Hawman</u>			4. DATE OF DEATH Month <u>3</u> - Day <u>12</u> - Year <u>1959</u>		
5. SEX <u>Female</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>3-13-1883</u>	9. AGE (In years last birthday) <u>75</u>	FUNDER YEAR Months _____ Days _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>DeKalb Co. Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Gorman Bauer</u>		13b. MOTHER'S MAIDEN NAME <u>Sophia Knorr</u>		14. NAME OF HUSBAND OR WIFE <u>Alpha Hawman</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>487-42-6813</u>	17. INFORMANT <u>Alpha Hawman</u> Address <u>Stewartsville Mo.</u>
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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>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertension</u>	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>331X</u>	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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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
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21. I attended the deceased from <u>1951</u> to <u>March 12, 1959</u> and last saw her <u>him</u> alive on <u>March 12, 1959</u> Death occurred at <u>4:12</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>E. J. Dwyer</u> (Degree or title) <u>MD-2</u>	22b. ADDRESS <u>Stewartsville, Mo.</u>	22c. DATE SIGNED <u>3/13/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-14-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ridgeville Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>DeKalb Co. Mo</u>
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24. FUNERAL DIRECTOR <u>W.E. Summerfield</u> ADDRESS <u>Stewartsville</u>	25. DATE RECD. BY LOCAL REG. <u>3-18-59</u>	26. REGISTRAR'S SIGNATURE <u>Roscoe Davidson</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

MAY 4 1959

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 .....  
working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *W. E. Summersfield* .....

Licensed Embalmer No. *3007* .....  
P. O. Address, *Stewartville Md* .....

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.