

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-022393

FILED JUL 8 1959

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 110

STATE FILE NUMBER

|  |  |  |  |
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| 1. PLACE OF DEATH<br>a. COUNTY <b>Phelps</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Pulaski</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Rolla</b>                            |  | Length of stay in 1b<br><b>20 months</b>   | c. CITY OR TOWN <b>Dixon</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>McFarland Nursing Home</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|--|--|---|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Emma</b> Middle <b>Grisham</b> Last <b>Hawkins</b> |  |  | 4. DATE OF DEATH<br>Month <b>6</b> Day <b>27</b> Year <b>1959</b> |  |  |  |
|--|--|--|---|--|--|--|

|                         |                                  |   |                                      |                                     |                           |                        |       |      |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---------------------------|------------------------|-------|------|
| 5. SEX<br><b>Female</b> | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/16/1883</b> | 9. AGE (last birthday)<br><b>75</b> | IF UNDER 1 YEAR<br>Months | IF UNDER 24 HR<br>Days | Hours | Min. |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---------------------------|------------------------|-------|------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b> | 11. BIRTHPLACE (City and state or country)<br><b>Marion County, Missouri</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b> |
|---|--|--|--|

|  |   |   |
|--|---|---|
| 13a. FATHER'S NAME<br><b>Andy Craine</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Martha Bull</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Lewis Hawkins</b> |
|--|---|---|

|   |                                     |   |
|---|-------------------------------------|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>X</b> | 17. INFORMANT Address<br><b>Mr. Joe Craine, 3938 McRee, St. Louis, Mo</b> |
|---|-------------------------------------|---|

|  |            |                                  |
|--|------------|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Nephrosia</b> |            | 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) |                                  |

|   |   |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
|---|---|

|  |   |  |
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| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input 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.) |
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|   |                  |
|---|------------------|
| 20c. TIME OF INJURY<br>Hour<br>a.m.<br>p.m. | Month, Day, Year |
|---|------------------|

|  |  |   |
|--|--|---|
| 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<br>COUNTY<br>STATE |
|--|--|---|

21. I attended the deceased from 11-2 57 to 6/27/59 and last saw her alive on 6/27/59  
Death occurred at 4:30 P. on the date stated above, and to the best of my knowledge, from the causes stated.

|                                      |                   |                                 |                                    |
|--------------------------------------|-------------------|---------------------------------|------------------------------------|
| 22a. SIGNATURE<br><i>[Signature]</i> | (Degree or title) | 22b. ADDRESS<br><b>Rolla Mo</b> | 22c. DATE SIGNED<br><b>6/27/59</b> |
|--------------------------------------|-------------------|---------------------------------|------------------------------------|

|  |                               |  |   |
|--|-------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>6/29/1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fairview Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Marion County, Missouri</b> |
|--|-------------------------------|--|---|

|   |         |  |   |
|---|---------|--|---|
| 24. FUNERAL DIRECTOR<br><b>Gilbert Funeral Home, Inc., Dixon, Mo.</b> | ADDRESS | 25. DATE RECD. BY LOCAL REG.<br><b>June 29, 1959</b> | 26. REGISTRAR'S SIGNATURE<br><b>Nadine L. Stoll</b> |
|---|---------|--|---|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Maurice E. Schu

Licensed Embalmer No. 4505

P. O. Address Dixon, Missouri

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