

RL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031520

FILED VS OCT 13 1959

042

1000

993

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

IDED

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 2 years	c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3501 S. 30th St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LILLIE Middle B. Last HAWKS	4. DATE OF DEATH Month Sept. Day 27, Year 1959
---	--

5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/21/1876	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-------------------------	----------------------------------	---	--------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Clay County, Mo.	12. CITIZEN OF WHAT COUNTRY USA
---	--	---	---

13a. FATHER'S NAME John Andrew Wentworth	13b. MOTHER'S MAIDEN NAME Susan Jane Sisson	14. NAME OF HUSBAND OR WIFE E. A. Hawks
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT George Hawks, 3501 S. 30th, St. Joseph, Mo.
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis	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)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

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 _____ a.m. _____ 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 COUNTY _____ STATE _____
--	--	--

21. I attended the deceased from **5-12-59** to **9-27-59** and last saw her alive on **9-27-59**
Death occurred at **12:15p.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. Mothershead M.D.	22b. ADDRESS 2603 Fredrick	22c. DATE SIGNED 9-29-59
--	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 9/28/1959	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Tulsa Oklahoma
---	-------------------------------	------------------------------------	--

24. FUNERAL DIRECTOR Kester-Bauman	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Oct. 1, 1959	26. REGISTRAR'S SIGNATURE Mr. Clark Goodell
--	-----------------------------------	---	---

DOCUMENT

BY AFFIDAVIT OF J. Mothershead M.D. 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 South J.

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.