RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–032381

STATE FILE NUMBER

FILED VS SEP 23 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4251

DED

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City
Length of stay in 1b: 68 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Research Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 750 West 47th St.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: OTHMER Middle: S. Last: HAWKINSON
4. DATE OF DEATH: Month: August Day: 31 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2-20-1891
9. AGE (last birthday): 68
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): Retired - Caretaker
10b. KIND OF BUSINESS OR INDUSTRY: Hotel
11. BIRTHPLACE (City and state or country): Kansas City, Ks.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Charles H. Hawkinson
13b. MOTHER'S MAIDEN NAME: Ida Christine Erickson
14. NAME OF HUSBAND OR WIFE: None
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.: None
17. INFORMANT: Mrs. Lida P. Johnson Address: 750 W. 47th St.

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): Malnutrition — INTERVAL BETWEEN ONSET AND DEATH: 3 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): anorexia nervosa
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. ☐ Yes ☐ No ☐ Unknown
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 January 1955 to Aug 31, 1959 and last saw ~~him~~ her alive on Aug 31, 1959
Death occurred at 8:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: G. E. Kettner (Degree or title): M.D.
22b. ADDRESS: Kansas City Mo
22c. DATE SIGNED: 8/31/59

BY AFFIDAVIT OF G. E. Kettner

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Sept. 3, 1959
23c. NAME OF CEMETERY OR CREMATORY: Mt. Moriah Cemetery
23d. LOCATION (City, town, or county) (State): KansasCity, Missouri
24. FUNERAL DIRECTOR: Freeman Mortuary ADDRESS: Kansas City, Mo.
25. DATE RECD. BY LOCAL REG.: 9-1-59
26. REGISTRAR'S SIGNATURE: Never Mitchell

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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Dr. Glen G. Keller
Prof. Bell
GR1-2892
1:30-4:30

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 Elmer E. Freeman

Licensed Embalmer No. 481

P. O. Address Kansas City, Kan.

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