

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-041386
STATE FILE NUMBER

FILED VS NOV 25 1959

Registration District No. 301 Primary Registration District No. _____ Registrar's No. 67

V. S. 300
Rev. 1-57

910

1. PLACE OF DEATH a. COUNTY <u>Ripley</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ripley</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Naylor</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Naylor</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gen. Del.</u>		Length of stay in lb <u>3 Years.</u>	d. STREET ADDRESS (If outside, give location) <u>0918 Gen. Del.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LUTHER</u> Middle <u>WINTON</u> Last <u>HAWKS</u>			4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1959</u>
5. SEX <u>Male</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>March 6, 1876</u>
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Bonne Terre, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Melvin Hawks</u>	
13b. MOTHER'S MAIDEN NAME <u>Mattie Vandiver</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Ida May Hawks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>331X</u>	17. INFORMANT Address <u>Mrs. Ida May Hawks Naylor, 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>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Osteoarthritis (Bedfast 9 months)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Years</u>
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____	
20d. INJURY OCCURRED WHILE AT <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>Dec. 23, 1958</u> to <u>Nov. 6, 1959</u> and last saw <u>him</u> alive on <u>Nov. 5, 1959</u> Death occurred at <u>11:00 A M</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. L. Smith, D.O.</u>		(Degree or title) <u>2</u>	22b. ADDRESS <u>Box 68, Naylor, Mo.</u>
22c. DATE SIGNED <u>11-16-59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>11-8-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Doniphan, Missouri</u>
24. FUNERAL DIRECTOR <u>Russell-Ermert Corning, Ark.</u>		ADDRESS <u>BOX 377</u>	25. DATE RECD. BY LOCAL REG. <u>11-18-59</u>
26. REGISTRAR'S SIGNATURE <u>Flava Broz</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoRS 1949.

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.

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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 R. O. E. [Signature]

Licensed Embalmer No. 782

P. O. Address Corning, N.Y.

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.