

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS APR 18 1960

-60-014266

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 429 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b Lifetime	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 2704 Penn St.,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2704 Penn St., Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Orin Middle G. Last Hawman			4. DATE OF DEATH Month April Day 4 Year 1960			
--	--	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1885	9. AGE (last birthday) 74	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) Mgr. City Sales	10b. KIND OF BUSINESS OR INDUSTRY Swift & Co.	11. BIRTHPLACE (City and state or country) DeKalb County, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	---	---	--

13a. FATHER'S NAME W.W. Hawman	13b. MOTHER'S MAIDEN NAME Ella Healy	14. NAME OF HUSBAND OR WIFE Marguerite Hawman
--	--	---

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. 487-09-0137A	17. INFORMANT Address Mrs. Marguerite Hawman, St. Joseph, Mo.
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Thrombosis	10 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Diabetes mellitus	10 years
	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 4-3-57 to 4-4-60 and last saw ^{her}him alive on 4-1-60
 Death occurred at 1:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE (Degree, title) <i>J.L. Mothershead M.D.</i>	21b. ADDRESS 2608 Fredrick	21c. DATE SIGNED 4-7-60
--	--------------------------------------	-----------------------------------

22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE April 6, 1960	22c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	22d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
--	-----------------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS W. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. April 9, 1960	26. REGISTRAR'S SIGNATURE <i>Miss Clara Goodell</i>
---	--	--

DOCUMENT BY AFFIDAVIT OF J.L. Mothershead M.D. HOSPITAL 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 *Eric J. [Signature]*

Licensed Embalmer No. 4679

P. O. Address St. Joseph

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.