URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-039804

STATE FILE NUMBER

FILED VS NOV 1 0 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10593

ENDED

11/28/60

Booker Washington

Sunset Gardens of Memory

23c

DOCUMENT

BY AFFIDAVIT OF Funeral Director

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri
Length of stay in 1b: 2 Weeks
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL
Inside Limits: Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois COUNTY: Madison
c. CITY OR TOWN: Madison
Inside Limits: Yes X No ☐
d. STREET ADDRESS (If outside, give location): 807 Jefferson
Reside on Farm: Yes ☐ No X

3. NAME OF DECEASED (Type or print): First: ALBERTA Middle: NMN Last: HAWKINS
4. DATE OF DEATH: Month: OCTOBER Day: 29 Year: 1960
5. SEX: Female
6. COLOR OR RACE: Negro
7. Married X Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 3/15/19
9. AGE (last birthday): 41
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Alligator Lake, Miss. U.S.A.
12. CITIZEN OF WHAT COUNTRY:
13a. FATHER'S NAME: DONIE GALLOWAY
13b. MOTHER'S MAIDEN NAME: FANNIE WILLIAMS
14. NAME OF HUSBAND OR WIFE: EARL HAWKINS
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.: Unknown
17. INFORMANT: Earl Hawkins, 807 Jefferson Street, Address: Madison, Ill.

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): Lupus Erythematosis — INTERVAL BETWEEN ONSET AND DEATH: 1½ years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 705.4
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 XX No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO XX
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 8/24/59 to 10/29/60 and last saw her/him alive on 10/29/60
Death occurred at 11:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C. O. Vermillion, M. D. (Degree or title): C.O. Vermillion, M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 10/31/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11/5/60
23c. NAME OF CEMETERY OR CREMATORY: Sunset Gardens of Memory ~~Booker Washington~~
23d. LOCATION (City, town, or county) (State): Centreville Township, Ill.

24. FUNERAL DIRECTOR: Mariente Officer ADDRESS: 2114 Missouri E. St. Louis, Ill.
25. DATE RECD. BY LOCAL REG.: NOV 2 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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_____ Signed Frank Prokopf

Signature of Student Embalmer

Licensed Embalmer No. 435

P. O. Address St Louis

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.