

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 28 1960

-60-044458

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3354

INDEXED

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

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Dalton	T.	Hawkins		Nov	15	1960	

5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR
male	white		5-23-08	52	Months	Days
				Hours		Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
owner	Filling Station	St. Louis Co., Mo.	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Thomas B. Hawkins	Laura E. Behm	Isabelle Hawkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	490-01-9836	Jerrold Hawkins	Manchester, 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) <u>acute coronary occlusion</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerotic heart disease</u>	2 yr.
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.)
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20c. TIME OF INJURY	Hour	Month, Day, Year
	a.m. p.m.	

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
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21. I attended the deceased from Jan. 1959 to Nov. 15, 1960 and last saw her alive on 11-12-60
 Death occurred at 11:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deedee or title)	22b. ADDRESS	22c. DATE SIGNED
<u>W.B. Hedney M.D.</u>	<u>506 Meramec St. Rd. Valley Park, Mo.</u>	<u>11-17-60</u>

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)
Burial	11-18-60	Oak Hill Cemetery	Kirkwood 22,	Missouri

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Schrader Funeral Home	Ballwin, Mo.	11-18-60	<u>John C. Murphy M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Gene Matthews

Licensed Embalmer No. 4966

P. O. Address Flourish

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.