

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020488

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4992**

FILED MAY 23 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY Clay		c. CITY OR TOWN Corning		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARVEY Middle AUSTIN Last HAWKINS			4. DATE OF DEATH Month MAY Day 14 Year 1962			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 4/7/1893		9. AGE (last birthday) 69		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 Farmer			
10b. KIND OF BUSINESS OR INDUSTRY Farming				11. BIRTHPLACE (City and state or country) Pocahontas, Arkansas				12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Wylie Hawkins				13b. MOTHER'S MAIDEN NAME Sadie Pierce				14. NAME OF HUSBAND OR WIFE Myrtle 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. Nil		17. INFORMANT Myrtle Hawkins, Corning, Arkansas. Address					
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) CEREBRAL VASCULAR THROMBOSIS										1 YEAR	
DUE TO (b) PULMONARY EMPHYSEMA										10 YEARS	
DUE TO (c) 527.1											
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 MAY 10, 1962 to MAY 14, 1962 and last saw her him alive on MAY 14, 1962 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 <i>E. D. Vermillion, M.D.</i> (Degree or title)						22b. ADDRESS BARNES HOSPITAL			22c. DATE SIGNED 5/15/62 (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5/15/62		23c. NAME OF CEMETERY OR CREMATORY Local Cemetery			23d. LOCATION (City, town, or county) Corning, Arkansas				
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd., ADDRESS						25. DATE RECD. BY LOCAL REG. MAY 16 1962		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

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

Stanley F. Nixon

Licensed Embalmer No.

4193

P. O. Address

St. Louis

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.