

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-024712

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6475** STATE FILE NUMBER

**FILED JUL 6 1962**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>ST. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. Lukes Hosp</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1626 Orchid</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>S.</b> Last <b>Hawken</b>			4. DATE OF DEATH Month <b>6</b> - Day <b>29</b> - Year <b>1962</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-8-1892</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Water Div City of St. Louis</b>		11. BIRTHPLACE (City and state or country) <b>ST. Louis Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Otis R. Hawken</b>			13b. MOTHER'S MAIDEN NAME <b>Nettie Wagner</b>		14. NAME OF HUSBAND OR WIFE <b>Lillie Schott 8. Laymont</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lillie Schott 8. Laymont</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CEREBROVASCULAR ACCIDENT** INTERVAL BETWEEN ONSET AND DEATH **15-16 HRS.**

DUE TO (b) **ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE** **INDEF.**

DUE TO (c) **422.1**

Conditions, many, which gave rise to above cause (a), stating the underlying cause last.

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  No  Unknown

19. WAS AUTOPSY PERFORMED? YES  NO

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 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 **JUNE 6, 1961** to **JUNE 29, 1962** and last saw him alive on **JUNE 28, 1962**

Death occurred at **4:05** a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)  
**Dr. Russell Anderson, M.D.**

22b. ADDRESS  
**Northland Medical Bldg. 36**

22c. DATE SIGNED  
**6-29-62**

23a. BURIAL, CREMATION, REMOVAL (Specify)  
**Burial**

23b. DATE  
**7-2-62**

23c. NAME OF CEMETERY OR CREMATORY  
**Bellefontaine**

23d. LOCATION (City, town, or county) (State)  
**ST. Louis Mo**

24. FUNERAL DIRECTOR  
**O'Sullivan Muckie Knox Jennings**

ADDRESS **8806**

25. DATE RECD. BY LOCAL REG.  
**JUN 30 1962**

26. REGISTRAR'S SIGNATURE  
**Loan Smith, M.D.**

VS 300 Rev. 4/59

1  
2 **20**  
3  
4 **0**  
5 **0**  
6  
7 **0**  
8 **2**  
9  
10  
11  
12 **81-0**  
13

DATE AMENDED  
INSTEAD OF  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
SHOULD READ  
ITEM NO.

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Aufderheide  
Miss Howard [unclear]

**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,

~~by~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Lawrence O. Herling

Licensed Embalmer No. 4979

P. O. Address St. Louis, Mo

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.