

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-031575

STATE FILE NUMBER

Registration District No. 159 Primary Registration District No. 4249 Registrar's No. 26

DO NOT WRITE ON THIS STUB AMENDED

FILED AUG 28 1962

VS 300
Rev. 4/59

10500
24013

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Jefferson Co.</u> <u>CEDAR HILL NURSING HOME HILLS BORO MO</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HILLS BORO MO</u>		c. CITY OR TOWN <u>Florissant</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CEDAR HILL NURSING HOME</u>		d. STREET ADDRESS (If outside, give location) <u>25 Rolling Hills Drive</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>ADELAIDE O HAWKEN</u>			4. DATE OF DEATH Month Day Year <u>8 15 62</u>			
5. SEX <u>FE MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-75</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEVER WORKED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>ST LOUIS MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>WILLIAM M. HAWKEN</u>		13b. MOTHER'S MAIDEN NAME <u>EMMA OWEN</u>		14. NAME OF HUSBAND OR WIFE <u>NEVER MARRIED</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>GRACE SKELTON 25 ROLLING HILL DR FLORISSANT</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis</u>		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	
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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 <u>June 11, 1962</u> to <u>Aug. 12, 1962</u> and last saw her/him alive on <u>Aug. 12, 1962</u> Death occurred at <u>5:14 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>Edw. J. Sanders, M.D.</u>	22b. ADDRESS <u>1502 Olive Av</u>	22c. DATE SIGNED <u>8-16-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-17-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BELLEFONTAINE</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Florissant Mortuary</u>	25. DATE RECD. BY LOCAL REG. <u>8/18/62</u>	26. REGISTRAR'S SIGNATURE <u>Obeta Dickson</u>
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USE BLACK INK OR TYPEWRITER RIBBON

AUG 29 1962

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 James A. Lemmer

Licensed Embalmer No. 4142

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.