

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-044787

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 240 Primary Registration District No. 5827 Registrar's No. 44

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 19 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lewis Twsp</u>		c. CITY OR TOWN <u>Lilbourn</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>So. Project</u>		d. STREET ADDRESS (If outside, give location) <u>So. Project</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Hawkins</u>			4. DATE OF DEATH <u>November 13 1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>75</u>
11. BIRTHPLACE (City and state or country) <u>Union City, Tennessee</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Benjamin Franklin Hawkins</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Lillie Hawkins</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.	
17. INFORMANT <u>Lillie Hawkins-Lilbourn, Mo.</u>		Address	
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>Acute Cardiac Compensation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary infarct</u>			<u>24 hours</u>
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>Arterio Sclerosis - Cirrhosis of Liver</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
19. WAS AUTOPSY PERFORMED? YES <input 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 _____ 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 _____
21. I attended the deceased from <u>11-12-63</u> to <u>11-13-63</u> and last saw her/him alive on <u>11-13-63</u> Death occurred at <u>5:45 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. D. Cameron M.D.</u> (Degree or title)		22b. ADDRESS <u>Lilbourn, Mo</u>	22c. DATE SIGNED <u>11-13-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-15-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mounds Park</u>	23d. LOCATION (City, town, or county) <u>Lilbourn, Missouri</u> (State)
24. FUNERAL DIRECTOR <u>Ponder Funeral Home-Lilbourn, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>11-15-1963</u>	26. REGISTRAR'S SIGNATURE <u>Charles Simpson by H. P. Ponder</u>

USE BLACK INK OR TYPEWRITER RIBBON

**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 *Frank J. Pordus*

Licensed Embalmer No. 5030

P. O. Address *Lithonia, Ga.*

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.