

Registration District No. 347

Primary Registration District No. 5488

Registrar's No. _____

1. PLACE OF DEATH

(a) County Henry Clinton
(b) City or town _____
(c) Name of hospital or institution: R.R. #2
(d) Length of stay: In hospital or institution _____
In this community About 5 Months

8. (a) PRINT FULL NAME John Hawkins 25

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Fannie 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: June 27 1869
(Month) (Day) (Year)

8. AGE: Years 70 Months 5 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Baldwin Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Tavern

11. Industry or business General

12. Name Daniel Hawkins 9

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Jamena Wren

15. Birthplace Unknown Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Blacks Gishmen

(b) Address Clinton R.R. #2

17. (a) Inglwood (b) Date thereof 12 7 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____
18. (a) Signature of funeral director Sprix Son
(b) Address Clinton Mo
19. (a) 12-11-39 (b) W. J. Hamilton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town Springfield
(d) Street No. _____
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 5th
year 1939 hour 3p minutes _____ M.

21. I hereby certify that I attended the deceased from 9/5, 1939, to 12/5, 1939
that I last saw him alive on 12/5, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Disease Duration 4000

Due to 92 W

Other conditions Mitral Decker
(Include pregnancy within 3 months of death)

Major findings: Of operations None
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____
23. Signature Ed. Decker (M. D. or other) _____
Address Clinton Mo Date signed 12/7/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

REV. 8-17-39 I X19311

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 7,

District File Number 7-4065

Date Filed 1-9-40

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.....

John N. Anderson

....., Registered Apprentice No.

working under my personal supervision.

Signed

John N. Anderson

Licensed Embalmer No. 3647

P. O. Address

Clinton, 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 this body is not embalmed, above space should be left blank.