

FILED DEC 4 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43198

STATE FILE NUMBER

Registration District No. 336 Primary Registration District No. 6124 Registrar's No. 440

1. PLACE OF DEATH a. COUNTY <u>Shannon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shannon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Eminence</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Eminence</u> 1010 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Length of stay in 1b <u>years</u>	d. STREET ADDRESS (If outside, give location) <u>1010</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rose Ellen Hawkins</u>			4. DATE OF DEATH Month Day Year <u>Nov. 8, 1957</u>
5. SEX <u>Female</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>Nov. 7, 1871</u>
9. AGE (In years last birthday) <u>86</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Ft. Payne, Ala.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Chas. P. McClellan</u>	
13b. MOTHER'S MAIDEN NAME <u>Martha V. McCurty</u>		14. NAME OF HUSBAND OR WIFE <u>Andrew J. Hawkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Ben R. Wescott, Springfield, Mo.</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>Hypostatic pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Age & hip fracture of</u> DUE TO (c) <u>2 years duration - bad east</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>962X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 yr</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>47</u>		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT <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 <u>333</u>
21: I attended the deceased from <u>1953</u> to <u>death</u> and last saw her/him alive on <u>11-8-57</u> Death occurred at <u>8:25 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. F. Wilson D.D.</u>		22b. ADDRESS <u>Eminence Mo</u>	22c. DATE SIGNED <u>11-22-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/11/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Montier City Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Montier, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Duncan Funeral Home Mtn View, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 7, 1957</u>	26. REGISTRAR'S SIGNATURE <u>J. B. [Signature]</u>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

470

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 *Richard A. Horton*

Licensed Embalmer No. *5029*

P. O. Address *Mt. View, 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.