S. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAY 11 1948

Registration District No. 577

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14988

Primary Registration District No. 6076

Registrar's No. 1068

1. PLACE OF DEATH:
(a) County: Saint Louis
(b) City or town: Chesterfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Route #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St Louis
(c) City or town: Chesterfield
(If outside city or town limits, write "RURAL")
(d) Street No.: Route #1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Pearl Hawkins
3. (b) If veteran, name war: ---
3. (c) Social Security No.: none

4. Sex: Female
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Pete
6. (c) Age of husband or wife if alive: 52 years
7. Birth date of deceased: May (Month) 1st (Day) 1900 (Year)

8. AGE: Years 47 | Months 11 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace: unavailable (City, town, or county) (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: as above

FATHER
12. Name: unavailable
13. Birthplace: " (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: "
15. Birthplace: " (City, town, or county) (State or foreign country)

16. (a) Informant: Pete Hawkins
(b) Address: Rt. # 1 Chesterfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/27/1948 (Month) (Day) (Year)
(c) Place: burial or cremation: Chesterfield, Mo.
18. (a) Signature of funeral director: Chas. J. Gates
(b) Address: 4107 Finney Ave
19. (a) 4-27-48 (Date received local registrar) (b) Cecil C. Sharpe MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 23 day 1948 year 2 hour 30 minute A M.
21. I hereby certify that I attended the deceased from ....., 19....., to ....., 19.....;
that I last saw h..... alive on ....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death: Undetermined either heart death or embolism death
Due to: Chr. Myocarditis
Due to: .....
Other conditions: Hernia operation (include pregnancy within 3 months of death) 2 mo ago
Major findings:
Of operations: 1220
Of autopsy: .....

Duration

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

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? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature: C. O. Denny (M. D. or other) MD
Address: Creve Coeur, Mo Date signed 4-25-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

MAY 11 1948

STATEMENT BY LICENSED EMBALMER

I hereby certify that the M body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Thomas J. Gates, Registered Apprentice No. ....., working under my personal supervision.

Signed Thomas Gates

Licensed Embalmer No. 4259

P. O. Address 4107 7

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, fact should be so stated above.