

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29065

FILED SEP 14 1953

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>157</u>		PRIMARY REG. DIST. NO. <u>3028</u>		Registrar's No. <u>178</u>			
1. PLACE OF DEATH a. COUNTY <u>Jasper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carthage</u>		c. LENGTH OF STAY (in this place) <u>21 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township). OR TOWN <u>Carthage</u> <u>0 493</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1033 Olive St</u>				d. STREET ADDRESS (If rural, give location) <u>1033 Olive St</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>EDITH</u>			b. (Middle) <u>—</u>		c. (Last) <u>HAWKINS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 4, 1953</u>		
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>June 27-1899</u>		9. AGE (In years last birthday) <u>54</u> if under 1 year: Months _____ Days _____ if over 1 year: 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>at home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Aurora, Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Witherspoon</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Elzie C. 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. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>E.C. Hawkins, 1033 Olive, Carthage, Mo</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION, I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u> ANTECEDENT CAUSES <u>Morbid conditions, (if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Polecythemia</u> DUE TO (c) <u>Spinal Cord (injury + post-traumatic)</u> II. OTHER SIGNIFICANT CONDITIONS <u>20% S. L. of Blood</u> <u>osteochondroma hip RT +</u> <u>of 2 number years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>3 1/2 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>026x</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>2-21</u> <u>1942</u> , to <u>9-4-</u> <u>1953</u> , that I last saw the deceased alive on <u>9-3</u> <u>1953</u> , and that death occurred at <u>12 P. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>Carthage, Mo</u>		23c. DATE SIGNED <u>9-4-53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>Sept 5-1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Carthage, Mo</u>			
DATE REC'D BY LOCAL REG. <u>9-5-53</u>		REGISTRAR'S SIGNATURE <u>Lloyd B. Clinton MD</u> <u>139-0</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Knell Mortuary, Carthage, Mo</u>					

(Licensed Embalmers' Statement on Reverse Side)

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

RECEIVED SEP 10 1953

Jasper County Health Office
53-9-739

County File Number _____
Date Filed SEP 10 1953

MAR 1 1955

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
Student Embalmer

Signed Frank W. Kelle

Licensed Embalmer No. 4440

P. O. Address Carthage, 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, fact should be so stated above.