

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-015891
STATE FILE NUMBER

FILED APR 23 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

4138

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 25 ST. LOUIS CITY HOSPITAL #1		Length of stay in 1b #1		d. STREET ADDRESS (If outside, give location) 237 2626 DeKalb	
3. NAME OF DECEASED (Type or print) First Middle Last Marion G. Hawk			4. DATE OF DEATH Month Day Year April 12 1958		
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-1893	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and state or country) Goodland, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Alfred Hawk		13b. MOTHER'S MAIDEN NAME Nancy Strickland	
14. NAME OF HUSBAND OR WIFE Rosie Etta Hawk		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 353 09 6567	
17. INFORMANT Address Rosie E. Hawk, 2626 DeKalb		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0			
INTERVAL BETWEEN ONSET AND DEATH 10 Min. 10 Yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <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 4-9-58 to 4-12-58 and last saw her alive on 4-12-58 Death occurred at 11:20 AM on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Type or print) John W. Strzech M.D.			22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 4/15/58
23a. BURIAL, CREMATION, REMOVAL Removal		23b. DATE 4-15-1958		23c. NAME OF CEMETERY OR CREMATORY Goodland Cemetery	
23d. LOCATION (City, town, or county) Goodland, Missouri		23e. (State)			
24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette Ave.		25. DATE RECD. BY LOCAL REG. APR 15 '58		26. REGISTRAR'S SIGNATURE [Signature]	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *J. G. Farris*

..... Licensed Embalmer No. *3384*

P. O. Address *St. Louis*

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.