

FILED JUL 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25726

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 139

1. PLACE OF DEATH a. COUNTY <i>Saline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Missouri</i> b. COUNTY <i>Saline</i>	
b. CITY (If outside corporate limits, write RURAL and give township) <i>Marshall</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Marshall</i>	
c. LENGTH OF STAY (in this place) <i>Life-time</i>		d. STREET ADDRESS (If rural, give location) <i>410E Jackson</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>410E Jackson</i>			

3. NAME OF DECEASED (Type or Print) a. (First) <i>Robert</i> b. (Middle) <i>Anthony</i> c. (Last) <i>Lawrence</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>July 14 50</i>		
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Child</i>	
8. DATE OF BIRTH <i>Oct 29 48</i>		9. AGE (In years last birthday) <i>1 8 14</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Marshall, Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	

13a. FATHER'S NAME <i>Clarence Lawrence</i>		13b. MOTHER'S MAIDEN NAME <i>Josephine Robinson</i>		14. NAME OF HUSBAND OR WIFE <i>none</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT'S SIGNATURE OR NAME <i>Clarence Lawrence</i> ADDRESS <i>Marshall, Mo</i>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Arterial Poisoning</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 hr</i>	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <i>none</i>		<i>5866</i>	
		DUE TO (c) <i>Ingested Ant Poison</i>		<i>14</i>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<i>none</i>			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <i>Accidental</i>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>Marshall Saline Mo</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>July 14 1950 5^{PM}</i>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Blind obtained ant poison & drank unknown</i>	

22. I hereby certify that I attended the deceased from *July 14*, 1950, to *July 17*, 1950, that I last saw the deceased alive on *July 14*, 1950, and that death occurred at *10^{PM}* m., from the causes and on the date stated above.

23a. SIGNATURE <i>Robin M. ...</i> (Degree or title)		23b. ADDRESS <i>Marshall Mo</i>		23c. DATE SIGNED <i>7-15-50</i>	
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24a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>7/16/50</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Christ Church</i>	
				24d. LOCATION (City, town, or county) (State) <i>Marshall Saline Mo</i>	

DATE REC'D BY LOCAL REG. <i>July 16-1950</i>		REGISTRAR'S SIGNATURE <i>Sidney J Gray</i> 385		25. FEDERAL DIRECTOR'S SIGNATURE <i>Allen ...</i> ADDRESS <i>...</i>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 7/24/50
DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 7/24/50

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed _____

Signed _____

Student Embalmer

Licensed Embalmer No. 4220

P. O. Address _____

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.