

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

701

9521

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....  
 Township..... Primary Registration District No..... Registered No. 1866  
 City St. Louis (No. 2706 Eads ave) St. .... Ward

**2. FULL NAME**

Matthew Lawson  
 (a) Residence. No. 2706 Eads ave 15<sup>th</sup> Ward. (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 25 yrs. 6 mos. 12 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Laura Lawson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 22 - 1892

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>25</u>	<u>6</u>	<u>12</u>	

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work chambermaid  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis  
 (STATE OR COUNTRY)

10. NAME OF FATHER Matthew Lawson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary English

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis  
 (STATE OR COUNTRY)

14. INFORMANT Laura Lawson  
 (Address) 2706 Eads ave

15. FILED 6 19 Mar 6 Starkloff  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 3<sup>rd</sup> 1920

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920, to Feb 3 1920  
 (that I last saw him/her) alive on Feb 3 1920, and that death occurred, on the date stated above, at 10 P. m.

18. THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
11A Bronchial Pneumonia  
0770

CONTRIBUTORY (SECONDARY) Influenza  
 (duration) yrs. mos. 4 ds.  
 (duration) yrs. mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No. DATE OF.....  
 WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) St Louis Schuchert M. D.  
Feb 5 1920 (Address) 2200 Chatterbox ave

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary DATE OF BURIAL Feb. 7 1920

20. UNDERTAKER Wacker-Helders 2120 ADDRESS 2331 No. Perry

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

