

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

16659

1. PLACE OF DEATH

County Pemiscot Registration District No. 653 File No. _____
 Township Cottland Primary Registration District No. 5865- Registered No. 44
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Odell Lawson

(a) Residence. No. _____ St. _____ Ward _____ (If nonresident give city or town and State)
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

May 3 1923

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, <u>hr.</u> or <u>min.</u>
0	0	0	0

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

Portageville, Mo.

(STATE OR COUNTRY)

10. NAME OF FATHER

Odell Lawson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Mattie Handley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

16. DATE OF DEATH (MONTH, DAY AND YEAR)

May 3, 1923

17.

I HEREBY CERTIFY, That I attended deceased from May 3, 1923, to May 3, 1923
 that I last saw him alive on May 3, 1923, and that death occurred, on the date stated above, at 6 A.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

member, Premature Birth

CONTRIBUTORY (SECONDARY)

1611

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Mrs. G. S. McFarlane, M. D.

5/4/1923 (Address) Portageville Mo.

*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

DATE OF BURIAL

Portageville, Mo. May 4, 1923

20. UNDERTAKER

ADDRESS

Pellerly Supply Portageville Mo.

14. INFORMANT

Odell Lawson
 (Address) Portageville Mo.

15. FILED

5/10, 1923 J. W. Johnson
 REGISTRAR

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 8 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

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

PLACE OF DEATH
County Laclede
Township Bethel
or
Village
or
City (NO. _____) St. _____ Ward _____

Registration District No. 114 File No. 9
Primary Registration District No. 5869 Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Chas Lawson Jr.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE W SINGLE Married
MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH 5 3 1923
(Month) (Day) (Year)

AGE Five years If LESS than 1 day, ___ hrs. or ___ min.?
yrs. mos. ds.

OCCUPATION (a) Trade, profession, or particular kind of work Inspector
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Mo SUPPLY

PARENTS
NAME OF FATHER Chas Lawson
BIRTHPLACE OF FATHER (City or town, State or foreign country) Albany
MAIDEN NAME OF MOTHER Mattie Hayes
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Lawson
(ADDRESS) 1140 Portage Ave

Filed May 3 1923 Joel Adams
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 5-3-23
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw alive on 5-3-23, 191____,
and that death occurred, on the date stated above, at _____ p.m.

THE CAUSE OF DEATH* was as follows:
E. nature of mouth
of measles
161A (Duration) yrs. mos. ds.

Contributory (SECONDARY) _____ (Duration) yrs. mos. ds.
(Signed) H. H. ... M. D.
5-3-23 (Address) 1140 Portage Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL May Ward Cemetery DATE OF BURIAL 5-4-23
UNDERTAKER R. D. Young ADDRESS Portage Ave Mo

PLACE OF DEATH

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

County _____
 Township _____ or _____
 Village _____ or _____
 City _____ (NO. _____) _____ St. _____ Ward _____
 Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____
 SINGLE _____ MARRIED _____
 WIDOWED _____ OR DIVORCED _____
 (If write the word)
 DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year) _____
 AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min. ?

OCCUPATION _____
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 16659

BIRTHPLACE _____
 (City or town, State or foreign country)

NAME OF FATHER _____
 BIRTHPLACE OF FATHER _____
 (City or town, State or foreign country)

MAIDEN NAME OF MOTHER _____
 BIRTHPLACE OF MOTHER _____
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (ADDRESS) _____

Filed _____ 191 _____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ 191 _____

I HEREBY CERTIFY, that I attended deceased from _____, 191 _____, to _____, 191 _____, that I last saw h _____ alive on _____, 191 _____, and that death occurred, on the date stated above, at _____ M.

The CAUSE OF DEATH was as follows:

Contributory _____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____ (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ 191 _____ (Address) _____ M. D.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence.

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____ 191 _____

UNDERTAKER _____

ADDRESS _____