

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

6668

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City **St. Louis** (No. **1916<sup>a</sup>** **Franklin**)

File No.....  
 Registered No. **1898**  
 St. .... Ward)

**2. FULL NAME**

**James Lawson**  
 (a) Residence, No. .... St., **21** Ward.  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **married**

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**About 43 - -**

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Miss**

10. NAME OF FATHER **Frank Lawson**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

12. MAIDEN NAME OF MOTHER **Lawson Bond**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

14. INFORMANT **R. W. Simmons**  
 (Address) **1916<sup>a</sup> Franklin**

15. FILED **25** 19**27** **Marie Starreff**  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **2-24 1927**

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at **7:30 a** m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
**Chronic Myocarditis**  
**958**  
**9013**  
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **9013**  
 (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? DATE OF .....

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) **R. W. Simmons**, M. D.  
 19..... (Address) **257<sup>a</sup> Crowned**

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURES OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **St Matthews** DATE OF BURIAL **2-26 1927**

20. UNDERTAKER **Arthur J. Donnelly** ADDRESS **2039 Wash St**

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.

