OCT 26 1927.

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

Do not use this space.

File No. 27525
Registered No.

1. PLACE OF DEATH

County: Jasper — Registration District No. 408
Township: Marion — Primary Registration District No. 3020
City: Carthage (No. ..... St. ..... Ward)

2. FULL NAME Josie Lawson

(a) Residence. No. 110 W. 18th. St., ... Ward. Pittsburg, Kansas
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept. 19. 1865

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
	62	✓	✓	

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

9. BIRTHPLACE (CITY OR TOWN): Des. Moines
(STATE OR COUNTRY): Iowa

PARENTS

10. NAME OF FATHER: Lra Thornton
11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Ohio
12. MAIDEN NAME OF MOTHER: Sarah Thornton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Indiana

14. INFORMANT: Mrs. h. A. Kelley
(Address): Pittsburg, Kansas

15. FILED Sept 20, 1927. S. B. Christian, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept. 19th/ 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 18, 1927 to 9-19, 1927, that I last saw h. alive on ....., 19....., and that death occurred, on the date stated above, at 2:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart Block
11 sec
95 A (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY): Chronic Stomach affection (duration) ..... yrs. ..... mos. ..... 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? Clinical
(Signed) S. B. Taylor, M. D.
9-19, 1927 (Address) Carthage 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Forrest Park Cemt. — DATE OF BURIAL: 9-21 1927

20. UNDERTAKER: Steele Mud. Co. — ADDRESS: West City

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.

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