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

Do not use this space.

17408

File No. [illegible]

Registered No. .....

1. PLACE OF DEATH

County Jackson — Registration District No. 399

Township Kaw — Primary Registration District No. 1007

City Kc Mo (No. 823 W 23rd St St. ..... Ward)

2. FULL NAME Benjamin F. Lawson

(a) Residence. No. 823 W 23rd St., 3 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: wh

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Don't Know

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Don't Known

7. AGE: 42 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Don't Know I

(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) Mo

PARENTS

10. NAME OF FATHER: Jos Lawson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Louisville Ky

12. MAIDEN NAME OF MOTHER: Katherine Porter

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

14. INFORMANT: Chas. Lawson
(Address) 1507 Brooklyn

15. FILED 5/31, 1928 M. M. Crowe Assn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) May 30 1928

17. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner ....., 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Throat cut Knife

174

75B

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Alcoholism

(duration) ..... yrs. ..... mos. ..... ds.

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

3 DID AN OPERATION PRECEDE DEATH? Yes DATE OF May 29-1928

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Glenn Carbaugh, M. D

5/30, 1928 (Address) Deputy Coroner

*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: Slater Mo

DATE OF BURIAL: 6/1 1928

20. UNDERTAKER: R. V. Lindsey

ADDRESS

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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Jackson — Registration District No.: 399 — File No.:
Township: — Primary Registration District No.: 1052 — Registered No.: 23871
City: K City (No. ..... St. ..... Ward)

2. FULL NAME: Benjamin F. 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. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Div.

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

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

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

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)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 5/31, 1928 M. M. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 30 1928

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 ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Thrombosis — Rectal — Rectum
Stomach —
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Alcoholism
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? No
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? Path. Exam
(Signed) [illegible] M.D.
, 19 (Address) [illegible]

*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 | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-17405