APR 30 1929

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

Do not use this space.

11924

1. PLACE OF DEATH
County Pulaski
Township Jerico
City ..... (No. ..... St. ..... Ward)

Registration District No. 716
Primary Registration District No. 5945

File No. .....
Registered No. 9

2. FULL NAME Nancy A. Lawrence

(a) Residence. No. ..... St., ... 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 Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 30 1862

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	4	4	

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) Housework
(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky

PARENTS

10. NAME OF FATHER Abner Lodge
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Elizabeth Walters
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky

14. INFORMANT Mrs Fred Lawrence
(Address) Crocker Mo

15. FILED 3/4 1929 W. Lell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 4 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 15th 1929, to March 4 1929, that I last saw h. alive on March 2 1929, and that death occurred, on the date stated above, at 9.50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza
Lobar Pneumonia
(duration) ..... yrs. 23 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Bronchio Pneumonia
(duration) ..... yrs. 7 mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED Place of death
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) W. Lell, M. D
3/4, 1929 (Address) Crocker 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 Concord Cemetery — DATE OF BURIAL 3/5 1929

20. UNDERTAKER Paul Hoop — ADDRESS Crocker Mo

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.