

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

Do not use this space.

Presnell
27 1929

18890

1. PLACE OF DEATH

County *New Madrid* Registration District No. *345* 1135
 Township *West* Primary Registration District No. *5799* 5799
 City *New Canaan* St. _____ Ward _____

2. FULL NAME

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 9 1928*

7. AGE Years *0* Months *19* Days *1* If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *New Madrid Mo*
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER *Willie Lawson*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *White Co Mo*
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Betha Jones*

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

14. INFORMANT *Grown Drake*
 (Address) *Canaan*

15. FILED *6/10 1929* *D. P. Philips*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 10 1929*

17. I HEREBY CERTIFY, That I attended deceased from *May 8*, 1929, to *May 10*, 1929, that I last saw him alive on *May 10*, 1929, and that death occurred, on the date stated above, at *11:00 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia
11A
167A (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED? *MO*
 IF NOT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) *W. Presnell*, M. D.
 5711, 1929 (Address) *Shelton 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 *Carpenter* DATE OF BURIAL *5/11 1929*

20. UNDERTAKER *H. Welch* ADDRESS *Shelton Mo*

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County N. Madrid Registration District No. 1133 File No. _____
 Township West Primary Registration District No. 5799 a Registered No. 4
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Owille Junior Lawson
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 9 - 1928

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
10 1

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) New Madrid Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Willis Lawson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) White Co Mo
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Bertie Jones

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

14. INFORMANT Ernest Drake
 (Address) Conalou

15. FILED July 10, 1929 Jas H. Kachel REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 10 1929

17. I HEREBY CERTIFY that I attended deceased from May 8 1929 to May 10 1929
 that I last saw him falling on May 10 1929, and that death occurred, on the date stated above, at 11:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY Influenza
 (SECONDARY) (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? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) G. W. Gressell, M. D.

. 19 _____ (Address) Sikeston 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 _____ DATE OF BURIAL _____

Cremated 3/11 1929

20. UNDERTAKER H. J. Welsh ADDRESS Sikeston Mo

RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

RE.

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