

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

Do not use this space.

704
5936a
34735

1. PLACE OF DEATH
 County Bolt Registration District No. 704 File No. 7771
 Township Wishart Primary Registration District No. 5936a Registered No. 704
 City (No. 704) St. _____ Ward _____

2. FULL NAME Joseph W 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 Male 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) Feb-18-1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70 7 23

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work blacksmith
 (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) Bolt Mo Tenn

10. NAME OF FATHER John Lawson

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

12. MAIDEN NAME OF MOTHER Carlin Gibbs

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

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 11 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1929, to Oct 11, 1929, that I last saw him alive on Oct 9, 1929, and that death occurred, on the date stated above, at 6-50 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
aortic regurgitation
11 1/2 (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (SECONDARY) influenza
 (duration) 6 yrs. 0 mos. 0 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? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) S E Hammon M. D.
19 (Address) Bolivar 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.

14. INFORMANT Jim Lawson DATE OF BURIAL Oct 12 1929
 (Address) Bolivar Mo

15. FILED Oct 12 1929 Mrs. Grace Dawn REGISTRAR ADDRESS Bolivar Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Common

20. UNDERTAKER Milton Blue

WRITE PL
 N. B.—Every item of information known to you should be stated EXACTLY. PHYSICIANS only 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 Dick
Township Arshart
City (No.)

Registration District No. 2704
Primary Registration District No. 5936 a

File No.
Registered No. 17
St. Ward

2. FULL NAME

Joseph W. Lawton
(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) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 18-1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
70 7 23

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Blacksmith
(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) Dick Co. Mo.

10. NAME OF FATHER John Lawton

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

12. MAIDEN NAME OF MOTHER Caroline Gibbs

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

14. INFORMANT Jim Lawton
(Address) W. Main St. Mo.

15. FILED Dec 11, 1929 Wm. H. Taylor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 11-1929

17. I HEREBY CERTIFY that I attended deceased from Oct 5 to Oct 11, 1929 that I last saw him alive on Oct 9, 1929, and that death occurred, on the date stated above, at 6:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute degeneration

CONTRIBUTORY (SECONDARY) Influenza
(duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Place of death

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) D. E. Harmonhill M. D.

Oct 12, 1929 (Address) Bolivar 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 Exxon Cemetery DATE OF BURIAL Oct 12 1929

20. UNDERTAKER Hutchison Blue ADDRESS Bolivar Mo

WRITE IN INK, WITH UNFADING INK---THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCASIONS should state CAUSE OF DEATH in plain terms, so that it can be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

1929
34735