

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

Do not use this space.

749

**1. PLACE OF DEATH**

County Generty  
Township \_\_\_\_\_  
City Stamberg MO

Registration District No. 314  
Primary Registration District No. 4190

File No. \_\_\_\_\_  
Registered No. 2  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Eddie Kela Lawter

(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 ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 9-1906

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
23 6 15

**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) Stamberg MO  
(STATE OR COUNTRY)

10. NAME OF FATHER Henry Jennings  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Jowa  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Rosie Adair  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Jowa  
(STATE OR COUNTRY)

14. INFORMANT Clarence Lawter  
(Address) Stamberg MO

15. FILED 1/26. 1930 C. J. Bennett  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 24 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1930 to Jan 24 1930 that I last saw h. alive on Jan 24 1930 and that death occurred, on the date stated above, at 10.30 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Abdominal Septicemia  
1/13/30  
1/30 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

1 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) C. J. Halloran M. D.  
, 19 (Address) Generty 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 Stamberg MO DATE OF BURIAL 1-27 1930

20. UNDERTAKER Lator F. Phillips ADDRESS Stamberg MO



**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 St. Louis Registration District No. 314 File No. ....  
 Township St. Bernard Primary Registration District No. 4190 Registered No. 3  
 City St. Bernard (No. ....) St. .... Ward)

2. FULL NAME

Edith Lela 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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)

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 3/15/30 C.S. Bernard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 24 1930

17. I HEREBY CERTIFY, That I attended deceased from .....

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:

Abdominal Septicemia  
after surgical operations  
per pus tubes

CONTRIBUTORY (SECONDARY)

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)....., M. D.

, 19 (Address)

\*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

20. UNDERTAKER

ADDRESS

19

SUPPLEMENTARY 138

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

