

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

Do not use this space **3500**

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **701**
Primary Registration District No. **104**
No. **1000** Hospital

File No.....
Registered No. **1000**
St. Ward)

2. FULL NAME *Henry Lawrence*

(a) Residence. No. **1026 N. High St.** St. **25** Ward.

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **Colo** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widower**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **unk**
7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
about 38 - -

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Laborer 178**
(b) General nature of industry, business, or establishment in which employed (or employer) **Odd jobs**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **La 8**

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

14. INFORMANT **Wm Dyer**
(Address) **Carroll Office**

15. FILED **May 1930** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 23 1930**

17. **No Physician in Attendance**
HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19....., and that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

**Asphyxiation,
Carbon dioxide**
due to being overcome by fumes while working in open to lead bath
CONTRIBUTORY (SECONDARY) **at 10th and High**
Jan 23/1930 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **Accident**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **John H. Hervey** M.D.

1/23, 1930 (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 **Patterson** DATE OF BURIAL **1-30-19 1930**

20. UNDERTAKER **Lishe Loney 3129 Lucas** ADDRESS

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.

