

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

Do not use this space.

12712

1. PLACE OF DEATH

County Jackson
Township Law
City Rivers City (No. 1424)

Registration District No. 399
Primary Registration District No. 1002

File No. 1630
Registered No. 1630
St. _____ Ward _____

2. FULL NAME

William F. Lawson

(a) Residence. No. 1424 Madison 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 3-1854

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
75- 10 8

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(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) Don't know

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Charlotte Lawson
(Address) 1424 Madison

15. FILED 4/14 30 M. M. Crowe REGISTRAR
ass

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 11 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, 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:

Suicide, fire arm
170 167 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Shot self with rifle (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy

(Signed) Haley M. Dues M. D.

4/11 30 (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 Highland Park DATE OF BURIAL 4/12 30

20. UNDERTAKER R. T. Dudley & Son ADDRESS Deputy 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.

WRITE PLAINLY, WITH UNFOLDING INK—THIS IS A PERMANENT RECORD

