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

Do not use this space.

158

1. PLACE OF DEATH
10 County Boone
Township Columbia
3 City Columbia (No. ..... St. ..... Ward)

Registration District No. 73
Primary Registration District No. 3006

File No. .....
Registered No. 2

2. FULL NAME William 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: Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Do Not Know

7. AGE: About 65 YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Coal hauler
(b) General nature of industry, business, or establishment in which employed (or employer): 14
(c) Name of employer: Dalton Coal Co.

9. BIRTHPLACE (CITY OR TOWN): Columbia
(STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: Edward Lawson
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Boone Co.
(STATE OR COUNTRY): Missouri
12. MAIDEN NAME OF MOTHER: Katherine Shields
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Boone Co
(STATE OR COUNTRY): Missouri

14. INFORMANT: George Lawson
(Address): Columbia Missouri

15. FILED 1/5/1931 F. C. Suggett REGISTRAR
by Selby

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 1 — 1 — 1931

17. I HEREBY CERTIFY, That I attended deceased from on Jan 1st, 1930, to ——— 19..., that I last saw him alive on Jan 1st, 1930, and that death occurred, on the date stated above, at 6 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
Complete Paralysis.
8VR
8VD
4 hrs
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): 82
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: no
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
(Signed) W. A. Norris, M. D.
, 19 (Address) Columbia 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: Calvary Cemetary
DATE OF BURIAL: 1-5 1931

20. UNDERTAKER: Stuart P. Parker
ADDRESS: Columbia Mo.

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

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.

FEB 23 1931