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

Do not use this space.

23945

1. PLACE OF DEATH
County Shelby — Registration District No. 830 — File No. 24
Township Salt River — Primary Registration District No. 6091 — Registered No.
City Shelbina (No. ..... St. ..... Ward)

2. FULL NAME Frank Beatty Lawman
(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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word):

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 27 1961

7. AGE: Years 61 — Months 11 — Days 16 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Real Estate Broker
(b) General nature of industry, business, or establishment in which employed (or employer) 154
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Paulon Ill
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER George A Lawman
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mary Beatty
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) N.Y.
(STATE OR COUNTRY)

14. INFORMANT P. M. Lawman
(Address) 838 N.Y. Life Bldg. K.C. Mo.

15. FILED 2-10, 1931 Madge Gooch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 24 - 1931

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 2:30 p.m. ?

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Heart attack
Myocarditis
(Found dead in bed)
(Verdict 8 coroner Jury)
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 930
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 95B

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) E. P. Thompson Coroner, M. D.
, 19 (Address) Shelbyville, N.

*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 ~~E Hayes~~ Paulon Ill — DATE OF BURIAL 19

20. UNDERTAKER E Hayes — ADDRESS Shelbina

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.

69

B.M. 28 1931

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 Shelby — Registration District No. 820
Township Salt River — Primary Registration District No. 6091
City ..... (No. ..... St. ..... Ward)

File No. .....
Registered No. 24

2. FULL NAME Frank Beatty Lawman

(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: M
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) June 27-1861

7. AGE — YEARS: 69 — MONTHS: 11 — DAYS: 17 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

FATHER
13. NAME .....
14. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME .....
16. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

17. INFORMANT ..... (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE ..... 19....

19. UNDERTAKER ..... (ADDRESS)

20. FILED 7-10 1931 Madge Gooch Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 14 1931

22. I HEREBY CERTIFY, That I attended deceased from ..... to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Other contributory causes of importance:	

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
.....
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) ....., M. D.
(Address) .....

SUPPLEMENTARY

PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write in plain terms, so that it may 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

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No..... , ... St. ..... Ward)

2. FULL NAME .....

(a) Residence: (If nonresident, give city or town and State)
(b) Usual place of abode: ..... St. ..... 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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 mins.

"Trade, profession, or particular kind of work done, as painter, sawyer, bookkeeper, etc. .....

Industry or business in which it was done, as silk mill, saw mill, factory, etc. .....

General kind work done at occupation (month and year) .....

11. Total time (years) employed in this occupation .....

..... OR TOWN)
..... y) .....

..... OR TOWN .....

..... y) .....

..... DATE ..... , 19 ..

..... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) ..... , 19 ..

22. I HEREBY CERTIFY, That I attended deceased from ..... , 19 ..... to ..... , 19 .....

I last saw him alive on ..... , 19 ..... Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

Other contributory causes of importance:

....

Name of operation ..... Date of ....

What test confirmed diagnosis? ..... Was there an autopsy? ....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... , 19 .....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

.....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) ..... , M. D.

(Address) .....

F-23945

RECORD
PHYSICIANS NOTIFICATION OF
VACCINATION
Transfer from file to
Transfer to file