

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

Do not use this space.

34807

1. PLACE OF DEATH

County Buchanan

Registration District No. 85

Township

Primary Registration District No. 1001

City St. Joseph

(No. St. Joseph's Hosp.)

File No.

Registered No. 11172

St.

Ward

2. FULL NAME Michael Thomas Lawlor

(a) Residence. No. _____ St., _____ Ward.

(Usual place of abode)

St.

Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

_____ yrs.

_____ mos.

_____ da.

How long in U.S., if of foreign birth?

_____ yrs.

_____ mos.

_____ da.

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

Ellen Lawlor

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

Sept. 29, 1865

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

67

1

9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Washington

(STATE OR COUNTRY)

Ireland

10. NAME OF FATHER

Thomas Lawlor

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Washington

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER

Maria Clonon

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Washington

(STATE OR COUNTRY)

Ireland

14.

INFORMANT

(Address)

Michael Lawlor

Plattburg Mo.

15.

FILED

11-8-32

John R. Bender

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

11-8-32

17.

I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1932, to Nov. 8, 1932 that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 12.10 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uremia
131 no. chronic Chronic (arterio-sclerosis)
47 (duration) _____ yrs. _____ mos. _____ da.
131 Arterio-sclerosis, general
CONTRIBUTORY (SECONDARY) hypertrophy Prostatic
(duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

Laboratory & hly exam.

(Signed)

Matthew A. Talty

M. D.

, 19 (Address)

411 Corby Rd. St. Joseph 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

DATE OF BURIAL

Plattburg Mo.

11-10 19 32

20. UNDERTAKER

ADDRESS

Nelson & O'Brien

Plattburg 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.

