

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.

JUN 20 1933

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

Do not use this space.

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1. PLACE OF DEATH **85**

County Buchanan Registration District No. 85

Township St. Joseph Mo. Primary Registration District No. 1001

City St. Joseph Mo. State Hospital # 2 Registered No. 15778

2. FULL NAME Wm. H. Lawrence St. _____ Ward _____

(a) Residence, No. Ludlow Mo. (Usual place of abode)

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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) About 1875

7. AGE YEARS 58 MONTHS 0 DAYS 0 IF LESS than 1 day,hrs. ormin.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer Common

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) Peoria

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) State Hospital Records

18. BURIAL, CREMATION, OR REMOVAL PLACE Congregate La DATE May 19, 1933

19. UNDERTAKER (ADDRESS) Deeman Funeral Home

20. MAY 16 1933 John K. Bender Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 15 1933

22. I HEREBY CERTIFY, That I attended deceased from Apr 28 1933 to May 15 1933

I last saw him alive on May 15 1933 Death is said to have occurred on the date stated above, at 3:00 m.

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

Social Anoxia Date of onset 5/11/33

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Other contributory causes of importance: Chronic Brights Disease

Name of operation None Date of _____

What test confirmed diagnosis? None Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? no Date of injury _____, 19 _____

Where did injury occur? no (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 non

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) W. H. Miles M. D.

(Address) State Hospital No. 2

