

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.

SEP 26 1933

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

Do not use this space.

27371

1. PLACE OF DEATH: 86 County District Registration District No. 719  
 Township Edin Primary Registration District No. 0950  
 City \_\_\_\_\_ No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME: Afford 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 7 1860

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>72</u>	<u>9</u>	<u>14</u>	

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

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) Iowa

13. NAME Thomas Lawson

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

15. MAIDEN NAME M. Walker

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

17. INFORMANT Dr. H. S. ...  
 (ADDRESS) ...

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Campford DATE Aug 27 1933

19. UNDERTAKER F. D. ...  
 (ADDRESS) ...

20. FILED Aug 24 1933 Durward Health  
 Registrar.

**MEDICAL CERTIFICATE OF DEATH**

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

22. I HEREBY CERTIFY, That I attended deceased from July 20 1933, to Aug 21 1933  
 I last saw him alive on July 20 1933. Death is said to have occurred on the date stated above, at 5:30 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Dropsical effusions in limbs and abdominal cavity  
Bright Disease  
 Other contributory causes of importance ...  
13241 3/4

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? No  
 If so, specify \_\_\_\_\_  
 (Signed) N. H. Johnson, M. D.  
 (Address) Greenwood Res.

