JUN 25 1935

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

Do not use this space.

17134

64
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8

1. PLACE OF DEATH

County Marion — Registration District No. 547 — File No.

Township Mason — Primary Registration District No. 3029 — Registered No. 164

City Hannibal (No. 1811, 36th St. Ward)

2. FULL NAME Ola Bell Lawless

(a) Residence. No. 1811 36th St., Ward. (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Married

5A. IF ~~MARRIED, WIDOWED, OR DIVORCED~~ ~~HUSBAND~~ OF (OR) WIFE OF Thomas S. Lawless

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 4th 1900

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
34	5	25	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) —
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER James W. Stern

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lincoln County
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Catherine Young

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo

14. INFORMANT Mr. Thomas S. Lawless
(Address) 1811 36th St. Hannibal Mo

15. FILED May 29, 1935 R. H. Isbister REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 28th 1935

17. I HEREBY CERTIFY, That I attended deceased from May 14, 1935, to May 28, 1935 that I last saw h. alive on 19 and that death occurred, on the date stated above, at 2 45 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Embolism following Delivery on May 14 1935

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

148

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinic

(Signed) John J. Kuchman, M. D.

, 19 (Address) 1001 Bldg Hannibal 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
Holy Rosary Cem Monroe City	5/31/35
20. UNDERTAKER	ADDRESS
James O'Donnell	Hannibal 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.