

JAN 24 1938

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

Do not use this space.

7 46499

1. PLACE OF DEATH
 County Repley Registration District No. 751
 Township Thibault Primary Registration District No. 5990
 City Raylor (No. _____) St. _____ Ward _____

2. FULL NAME Robert Larson
 (a) Residence, No. Raylor road St. _____ Ward _____
 (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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Louvinia Larson
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept - 11 / 1937
 7. AGE YEARS 57 MONTHS 2 DAYS 8 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. farmer
 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) unknown (STATE OR COUNTRY) Dist - 2

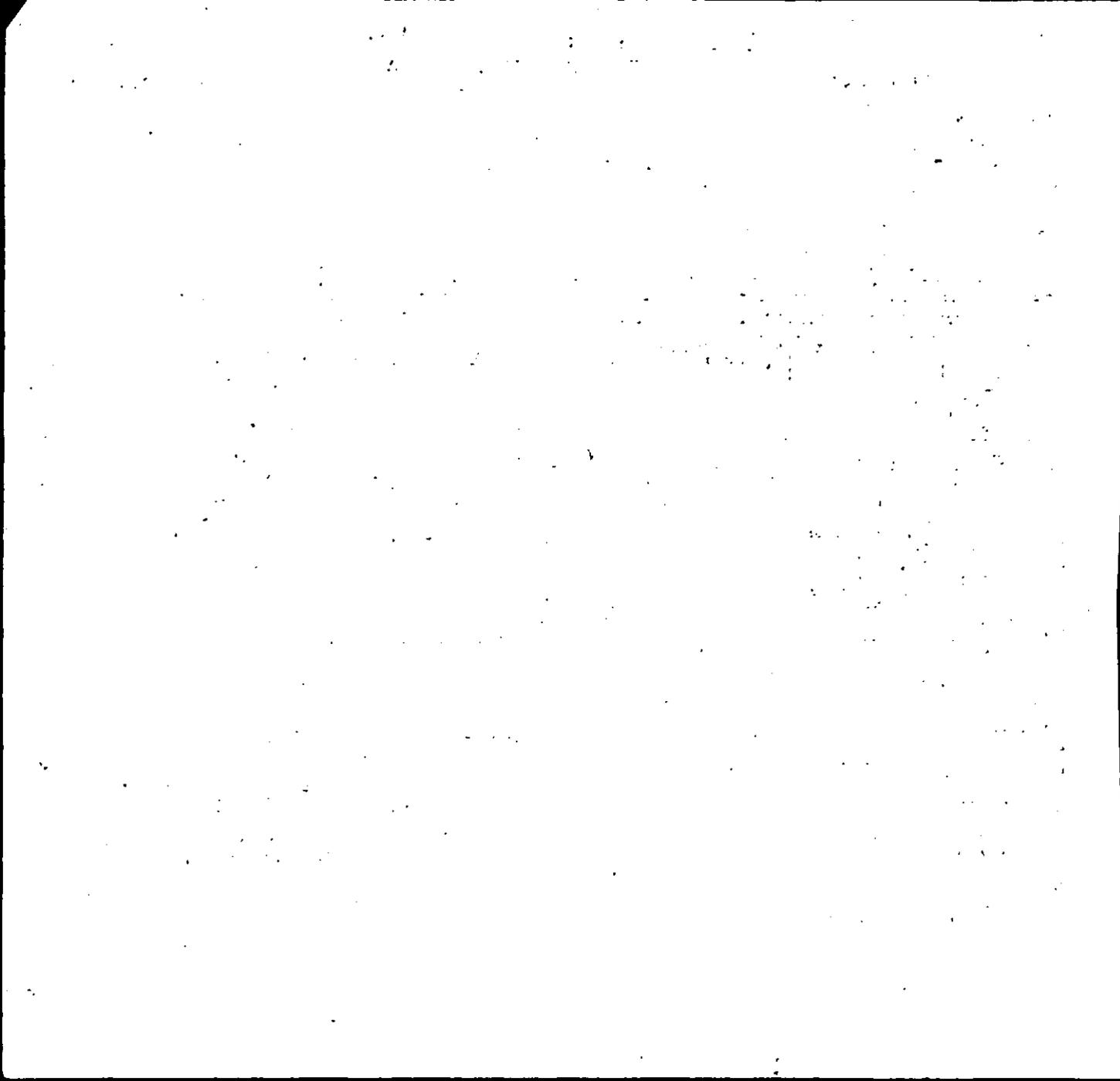
13. NAME unknown
 14. BIRTHPLACE (CITY OR TOWN) unknown (STATE OR COUNTRY)
 15. MAIDEN NAME unknown
 16. BIRTHPLACE (CITY OR TOWN) unknown (STATE OR COUNTRY)

17. INFORMANT Louvinia Larson (ADDRESS) Raylor Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Raylor R.R. DATE Nov. 18 1937

19. UNDERTAKER Minnie Lish (ADDRESS) Raylor Mo.
 20. FILED Nov 27 1937 Stewbitt Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 7 1937
 22. I HEREBY CERTIFY, That I attended deceased from Nov 1 1937 to Nov 7 1937
 I last saw him alive on Nov 6 1937 Death is said to have occurred on the date stated above, at 6 P. M.
 The principal cause of death and related causes of importance were as follows:
cardiac arrest of liver
 Date of onset _____
 Other contributory causes of importance: None
 Name of operation none Date of _____
 What test confirmed diagnosis? clinical 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? _____ (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) Stewbitt M. D.
 (Address) Raylor road



FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

46499
Do not use this space.

1. PLACE OF DEATH

(a) County Boyle Registration District No. 751
 (b) Township Thomas Primary Registration District No. 5890 Registered No. _____
 (c) City _____ (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Robert Lawson

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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) Sept 4 1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
57 2 3

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED Nov 9 1937 H. E. White Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 7 1937

22. I HEREBY CERTIFY, That I attended deceased from 19____ 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) H. E. White, M. D.

(Address) Traylor mo

SUPPLEMENTARY

