

REG. APR 1 9 1938

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

10735
Do not use this space.

1. PLACE OF DEATH *Greene*
 (a) County *Greene* Registration District No. *318*
 (b) Township *Springfield* Primary Registration District No. *2001* Registered No. *209*
 (c) City *Springfield* (d) Street No. *St. Johns Hospital* 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 *CORNELIUS (NEAL) LAWSON 50*
 (a) Residence, No. *703 NICHOLS* 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 *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 *Martha J. Lawson*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 20 - 1882*
 7. AGE YEARS *56* MONTHS *1* DAYS *17* If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Flagman*
 9. Industry or business in which work was done, as saw mill, bank, etc. *R.R. Co.*
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation *✓*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 7 1938*
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to *Mar. 7*, 1938
 I last saw him alive on *Mar. 7, 1938* at *7:30 P.* 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:
Coronary sclerosis
Coronary occlusion
Myocardial degeneration
Atrial fibrillation
 Date of onset _____
 Other contributory causes of importance: *930*
 Name of operation *None* Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? *Yes*
 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) *A.D. Sibley*, M. D.
 (Address) *923 N. Main*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*
 FATHER 13. NAME *James Lawson*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*
 MOTHER 15. MAIDEN NAME *Caroline*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*
 17. INFORMANT (ADDRESS) *Martha J. Lawson*
Springfield, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Humansville Mo.* DATE *March 9 1938*
 19. FUNERAL DIRECTOR (ADDRESS) *J. W. Klingner*
Springfield, Mo.
 20. FILED *318* 19 *38* *Chas. George* Local Registrar

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.

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STATEMENT BY LICENSED EMBALMER

I, J.B. Klingner, Licensed Embalmer No. 3358
hereby certify that the body recorded on the reverse side of this certificate was embalmed by Roy A. Gavin
1763 by Warren D. Hoblett
No. 4005 by Mr. Max Rhodes, Registered Apprentice No. 117
working under my personal supervision.
Signed J.B. Klingner
Licensed Embalmer No. 3358

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)