

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

26752  
 Do not use this space.

REC'D AUG 7 6 1938

**1. PLACE OF DEATH**

(a) County Vernon Registration District No. 875  
 (b) Township Washington Primary Registration District No. 6162  
 (c) City Merada (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. 2 mos. 19 ds. (f) How long in U. S., if of foreign birth yrs. mos. ds.

**2. PRINT FULL NAME**

Chas. W. Lawler 460  
 (a) Residence, No. State Hospital # 3 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 Lizzie Lawler  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 8, 1894  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
63 9 25  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer  
 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 \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

 21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 7 1938

 22. I HEREBY CERTIFY, That I attended deceased from May 14 1938, to Aug 2 1938

 I last saw him alive on Aug 2 1938. Death is said to have occurred on the date stated above, at 12:15 P.M.

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

Sen. paralysis of the insane (suffered of the C.N.S.)  
Date of onset ?

 Other contributory causes of importance: Chronic myocarditis 7

 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? \_\_\_\_\_ 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) T. J. O'Neil M. D.  
 (Address) Merada

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Henry Co. Mo. 0  
 FATHER 13. NAME Wm. R. Lawler 0  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. 0  
 MOTHER 15. MAIDEN NAME Amanda Richie  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
 17. INFORMANT (ADDRESS) Mrs. Lizzie Lawler, Clinton Mo.  
 18. BURIAL, CREMATION OR REMOVAL PLACE Clinton Mo. DATE Aug 3, 38  
 19. FUNERAL DIRECTOR (NAME) Funeral Home  
 20. FILED Aug 3, 1938 Local Registrar. 795

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.

THIS IS A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

*Mark Eickinger*

....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed *Mark Eickinger*

Licensed Embalmer No. *2656*

P. O. Address *Nevada, Mo.*

**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.)**

**If this body is not embalmed, above space should be left blank.**