

REC'D MAR 17 1938

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

6913
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 421
 (b) Township Jackson Primary Registration District No. 5375 Registered No. 23
 (c) City Jackson (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

Norman Ralph Lawrence
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (writes the word) Infant
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 5-1938
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 1 17

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-22-1938
 22. I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1938, to Dec. 22, 1938
 I last saw him alive on Dec. 22, 1938. Death is said to have occurred on the date stated above, at 8:30 m.
 The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 2
 9. Industry or business in which work was done, as saw mill, bank, etc. 3
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Acute Colitis Date of onset Dec 3, 38

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Des Moines Iowa

Other contributory causes of importance: Myocarditis Dec 2, 38

13. NAME Milburn Lawrence

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

15. MAIDEN NAME Katherine Miles

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

17. INFORMANT Milburn Lawrence (ADDRESS) Des Moines

18. BURIAL, CREMATION, OR REMOVAL PLACE Des Moines DATE 12/24/38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) First End Co Des Moines

20. FILED 3/6 1939 E Rutledge Local Registrar

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) Colarence E. Cooley, D.O. M.D.

(Address) 204 Main St., Keosauqua, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. FRICTION should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT TO BE FILED IN THE
OFFICE OF THE HEALTH COMMISSIONER
RECORDS SECTION

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, _____
_____, or by _____
Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.