

53 JUL 12 1939

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

20524
Do not use this space.

791
1008

Registered No. 5368

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No.....
(c) ^{or} City St. Louis (d) Street No. 1006 N. Compton 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 3 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Sarah Lawrence

(a) Residence, No. 1006 N. Compton St. 21 (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 F 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joiah Lawrence

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Abt. 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
Abt. 90 — — —

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Nil
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) Georgia

FATHER 13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Minnie Green
1006 N. Compton Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE E. St. Louis Ill. DATE 6/16 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. M. C. Green
3517 Laclède Ave.

20. FILED JUN 16 1939 J. F. Budek Local Registrar

No MEDICAL CERTIFICATE OF DEATH
21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/9 1939

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 4:15 P.M.
The principal cause of death and related causes of importance were as follows:

Senile Debility
Date of onset

Other contributory causes of importance:
arteriosclerosis

Name of operation..... Date of.....
What test confirmed diagnosis?..... 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 Joseph M. Quinn M.D.
(Signed) Deputy Coroner
(Address)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

50M-5-1009 I X18605

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. 1173.....

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.