

1939 OCT 20

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

32604
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson 3 Registration District No. 400
 (b) Township Prarie 1 Primary Registration District No. 5553B Registered No. 167
 (c) City _____ (d) Street No. Jackson County Home on the creek stream
 (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 William Lawless

(a) Residence, No. 92 Home 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) widower
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown 1868
 7. AGE YEARS 71 MONTHS - DAYS - If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
 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) Arb (STATE OR COUNTRY) 1

13. NAME Unknown FATHER 7

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

15. MAIDEN NAME Unknown MOTHER

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

17. INFORMANT Ernest Jackson (ADDRESS) 92 Home

18. BURIAL, CREMATION, OR REMOVAL Dental Co DATE 8-17-1939

19. FUNERAL DIRECTOR (NAME) Keller (ADDRESS) K & S

20. FILED 9/18/1939 Sara L. Lane Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 12 1939

22. I HEREBY CERTIFY, That I attended deceased from 8-1 1939 to 8-12 1939

I last saw h. - alive on 8-11 1939 Death is said to have occurred on the date stated above, at 4:10 a.m.

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

Mitral regurgitation Date of onset _____

Other contributory causes of importance: HTN

Name of operation _____ Date of _____

What test confirmed diagnosis clinical as 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) J. W. Greene M. D.
Independent (Address) _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Physicians should state cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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..... *Wm J Ward*

Licensed Embalmer No. *3991*

P. O. Address *5725 Virginia*

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.