

Registration District No. **7**

Primary Registration District No. **2002**

Registrar's No. \_\_\_\_\_

DEC 15 1939

1. PLACE OF DEATH:  
(a) County **Jasper**  
(b) City or town **Joplin**  
(c) Name of hospital or institution: **119 N. Gray**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **40 Yrs.**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Jasper**  
(c) City or town **Joplin**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **119 N. Gray**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Alfred Lawson 250**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Mar ch 9, 1869**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**70 7 30** hr. min.

9. Birthplace **Henry County Illinois**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Mail Carrier**  
**U. S. P. O. Dep't. 1**

11. Industry or business \_\_\_\_\_  
12. Name **John Lawson**  
13. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Jane Phillips**  
15. Birthplace **New York**  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Laverne Joutel**  
(b) Address **119 N. Gray**  
17. (a) **Burial** (b) Date thereof **11-8-39**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Funeral**

18. (a) Signature of funeral director **Hurlbut Und. Co.**  
(b) Address **212 Joplin St., Joplin, Mo.**  
19. (a) **11-9-39** (b) **E. J. James**  
(Date received local registry) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Nov** day **6**  
year **1939** hour **1:00** minute **--** P. M.

21. I hereby certify that I attended the deceased from **Nov 19-1939**  
to **Nov 6 1939**  
that I last saw him alive on **Nov 6** and that death occurred on the date and hour stated above.

Immediate cause of death: **Cerebral hemorrhage with paralysis and loss of memory**  
Due to **stroke, left femur at neck**  
Other conditions: **Cerebral hemorrhage with paralysis and loss of memory**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:  
(a) **Accident, suicide, or homicide (specify)** **fall in bus**  
(b) **Place of occurrence** **front of bus**  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_  
23. Signature **Joy E. Myers M.D.**  
Address **978 S. Main Joplin Mo 8-39**  
(M. D. or other)

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

RECEIVED

District Health Officer No. 6,

District File Number 1239-2476

Date Filed DEC 7 1939

*186 W  
118*

APR 2 1957

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 Steve D. Parker

Licensed Embalmer No. 2448

P. O. Address Wilmington

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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

39960  
Do not use this space.

1. PLACE OF DEATH

(a) County Gaspeur Registration District No. 411  
 (b) Township..... Primary Registration District No. 2002 Registered No.....  
 (c) City Joplin (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 Alfred Lawson

(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

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
70 7 30

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 6 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.

I last saw h..... alive on \_\_\_\_\_, 19\_\_\_\_. 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:

Chr. Peritonitis Chr. Valvular Heart Disease. Fracture left femur at neck.  
Cerebral Hemorrhage with Paralysis

Other contributory causes of importance:

fell in his home Oct. 6 - 1939, on floor at night when he got up to void

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 / on E. Myers M.D.  
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify. (Signed) R. E. Myers, M. D.

(Address) Joplin Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. 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.

SUPPLEMENT

