

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

43329  
 Do not use this space.

1. PLACE OF DEATH <sup>2</sup>  
 (a) County Gasconade Registration District No. 302  
 (b) Township 1 Primary Registration District No. 4181 Registered No. \_\_\_\_\_  
 or \_\_\_\_\_  
 (c) City Blair MO (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 5 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Joseph Lawrence  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
Blair MO (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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 7-1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
85 11 13

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. retired  
 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) St. Marie Illinois

FATHER 13. NAME James Lawrence  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

MOTHER 15. MAIDEN NAME Don't know  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT (ADDRESS) Eugene M. Woody

18. BURIAL, CREMATION, OR REMOVAL PLACE Cove Cemetery DATE 12-27 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gray & Leedy  
St. Clair MO

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-25 1939

22. I HEREBY CERTIFY, That I attended deceased from 12-18 1939, to 12-25 1939  
 I first saw him alive on 12-24 1939. Death is said to have occurred on the date stated above, at 5:20 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Auricular fibrillation  
Chronic myocarditis  
93C

Date of onset 12-18-39  
1931

Other contributory causes of importance:  
Left hemiplegia - hemorrhage intracranial on cystic basis. 1936

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 \_\_\_\_\_  
 (Signed) Paul Brenner M. D.  
273 (Address) Owensville, Mo

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

LiOh  
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**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 *K. M. Leroy*  
Licensed Embalmer No. *3601*  
P. O. Address *St. Clair, 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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Gasconade Registration District No. 302  
 (b) Township ..... Primary Registration District No. 4181  
 (c) City Bland (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

(a) Residence, No. Joseph Lawrence 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 (write the word) Wed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-25-1939

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

22. I HEREBY CERTIFY, That I attended deceased from

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

to ..... 19.....

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
85- 11 13

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:

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

Date of onset

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

Other contributory causes of importance:

FATHER 13. NAME

Name of operation ..... Date of

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

What test confirmed diagnosis? ..... Was there an autopsy? .....

MOTHER 15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19.....

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

Where did injury occur? ..... (Specify city or town, county, and State)

17. INFORMANT (ADDRESS)

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.....

Manner of injury ..... Nature of injury .....

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? ..... If so, specify

20. FILED 12-26 1939 J. A. Bunge Local Registrar

(Signed) Paul Breaner, M. D. Address Owensville Mo

SUPPLEMENTARY

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

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

