

FILED FEB 15 1946

Registration District No. 1796

Primary Registration District No. 3038

Registrar's No. 19

1. PLACE OF DEATH:  
 (a) County Saline  
 (b) City or town Marshall Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
362 South Jefferson St.  
 (If not in hospital or institution, write street number of location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether  
 In this community 25 yrs.  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Saline  
 (c) City or town Marshall, Mo.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 362 South Jefferson  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME MARtha A. LAWLESS  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. 170

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Jan day 24  
 year 1940 hour 5 minute 30 P M.

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced WIDOWED  
 6. (b) Name of husband or wife D. LAWLESS  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Sept. 11 1847  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1938  
 to Jan 24, 1940  
 that I last saw her alive on Jan 12 4, 1940  
 and that death occurred on the date and hour stated above.

8. AGE: Years 92 Months 4 Days 14  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Carcinoma on left temporal region Duration 3 yrs.

9. Birthplace Canton Mo.  
 (City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions X  
 (Include pregnancy within 3 months of death)

10. Usual occupation Housekeeper

Major findings: Of operations None  
 Of autopsy None  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER  
 11. Industry or business \_\_\_\_\_  
 12. Name James Lawless  
 13. Birthplace unknown unknown  
 (City, town, or county) (State or foreign country)  
 14. Maiden name unknown  
 15. Birthplace unknown unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Nettie Yowell  
 (b) Address Marshall Mo.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (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? \_\_\_\_\_

17. (a) Burial (b) Date thereof Jan 28 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director J. S. Surinney  
 (b) Address Marshall Mo.

While at work \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

19. (a) 1-26-40 (b) D. E. P.  
 (Date received local registrar) (Registrar's signature)

23. Signature A. R. Putnam (M. D. or other)  
 Address Marshall Mo Date signed 1-26-40

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.

RECEIVED  
District Health Officer No. 8  
District File Number *11/11/10*  
Date Filed

**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. *3235*

P. O. Address *Marshall, 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.**