U. S. No. 2
M—11-10-39
Rev. 5-17-39
I X25-32

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5946

FILED MAR 16 1940

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 147

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St. Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 221 Massachusetts Ave (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community: 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Buchanan

(c) City or town: St. Joseph (If outside city or town limits, write "RURAL")

(d) Street No.: 221 Massachusetts Ave (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: HARRIET H. LAWRENSON

3. (b) If veteran, name war: ____ 3. (c) Social Security No.: ____

4. Sex: Female 5. Color or race: White 6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: William H. Lawrenson 6. (c) Age of husband or wife if alive: 63 years

7. Birth date of deceased: Dec. 28th. (Month) (Day) 1878 (Year)

8. AGE: Years 61 Months 1 Days 10 If less than one day ____ hr. ____ min.

9. Birthplace: New York City (City, town, or county) N.Y. (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: Home

MOTHER FATHER

12. Name: August P. Bose

13. Birthplace: New York City (City, town, or county) N.Y. (State or foreign country)

14. Maiden name: Unknown

15. Birthplace: New York City (City, town, or county) N.Y. (State or foreign country)

16. (a) Informant: Wm. H. Lawrenson

(b) Address: 221 Massachussetts Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 12th. (Month) (Day) (Year)

(c) Place: burial or cremation: Memorial Park 1940

18. (a) Signature of funeral director: FLEEMAN & SON, INC.

(b) Address: 1916 Calhoun St. Joseph, Mo.

19. (a) Feb 14 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 8th. year 1940 hour 11.35 minute P. M.

21. I hereby certify that I attended the deceased from Nov 13, 1939 to Feby 8, 1940 that I last saw her alive on Feby 8, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Rectal	1 yr
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: Colostomy Mayo Clinic 1/6-/39. Of autopsy:	

PHYSICIAN — 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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: [signature] (M. D. or other)

Address: St. Joseph Mo. Date signed: 2/10/40

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(Licensed Embalmer's Statement on Reverse Side)

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 C. G. Swan

Licensed Embalmer No. 4082

P. O. Address St Joseph

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.