

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

MAY 15 1940

Registration District No. 6

Primary Registration District No. 5760

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Miller

(b) City or town Rural - Dixon, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____

(If not in hospital or institution, write street number or location) _____

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Miller

(c) City or town Rural
(If outside city or town limits, write "RURAL.")

(d) Street No. Dixon, Mo. R3
(If rural, give location)

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

3. (a) PRINT FULL NAME JOSEPHINE LAWSON

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4
year 1940 hour 6 minutes 0 M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Clifford Lawson

6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased Jan 25 1907
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 23, 1940 to April 4, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cranial Nephritis Duration 1939

8. AGE:

Years	Months	Days	If less than one day
<u>33</u>	<u>2</u>	<u>9</u>	hr. _____ min. _____

Due to _____

Due to _____

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

10. Usual occupation Housekeeper

Other conditions Pulmonary Tuberculosis 1939
(Include pregnancy within 3 months of death)

11. Industry or business _____

MOTHER FATHER

12. Name Joseph N. Leek

13. Birthplace El Dorado, Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Mrs. Lena Leek

15. Birthplace Esle Co., Mo.
(City, town, or county) (State or foreign country)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Marg Leek

(b) Address Springfield, Mo.

17. (a) Buried (b) Date thereof Apr. 5-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Levin Cem, Dixon, R3

18. (a) Signature of funeral director Chas Casey

(b) Address Springfield, Mo.

19. (a) April 5 (b) John J. Schmitt
(Date received local registrar) (Registrar's signature)

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? _____

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

23. Signature J. G. Leek (M. D. or other) _____

Address Dixon, Mo. Date signed _____

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

Rev. 5-17-39
1 X1051

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

Miller County Health Dep't

County File Number 40-6.1

Date Filed 5-14-40

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.....

Laura Adames....., Registered Apprentice No. 24
working under my personal supervision.

Signed Chasey.....

Licensed Embalmer No. 2694

P. O. Address Iberia, 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.