No. 2
1-10-39
17-39
X21492

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. 33378

Registration District No. 875 Primary Registration District No. 6162 Registrar's No. 224

1. PLACE OF DEATH:

(a) County VERNON

(b) City or town WASHINGTON TP. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: STATE HOSPITAL No 3 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 yrs 12 DAYS. (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LAWRENCE Co

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

(d) Street No. 200 EAST MYRTLE (If rural, give location)

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

3. (a) PRINT FULL NAME MRS MARY-L LAWSON

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife JOHN LAWSON

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

7. Birth date of deceased MARCH (Month) 24th (Day) 1868 (Year)

8. AGE: Years 72 Months 5 Days 9 If less than one day ..... hr. ..... min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business NONE

FATHER
12. Name TOM-BEVERAGE 0
13. Birthplace FAYETVILLE (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name SARAH BLEDSOE
15. Birthplace BOONVILLE.Co (City, town, or county) Mo. (State or foreign country)

16. (a) Informant STATE HOSPITAL No3 RECORDS.
(b) Address NEVADA Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/40 (Month) (Day) (Year)
(c) Place: burial or cremation Hospital Cemt -

18. (a) Signature of funeral director Marsh Eichinger
(b) Address Nevada Mo.

19. (a) 9-5-40 (Date received local registrar) (b) Albert E Davis (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 3 year 1940. hour 7 minute - P M.

21. I hereby certify that I attended the deceased from Oct 1st, 1939, to SEPT 3rd, 1940; that I last saw her alive on SEPT 3rd, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
ACUTE HEPATITIS	2 mo.
Due to CHR. CHOLECYSTITIS.	
Due to	
Other conditions CHR. NEPHRITIS. (Include pregnancy within 3 months of death)	
CHR MYOCARDITIS.	

Major findings:
Of operations
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: NO.
(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 Paul L. Barone (M. D. or other) M.D.
Address State Hosp No3 Date signed Sept 3rd

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 10-14-1417
Date Filed 10-8-40

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 .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed Mark Eichinger

Licensed Embalmer No. 2656

P. O. Address Nevada, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.