

Registration District No. **73**

Primary Registration District No. **3006**

DEC 10 1940
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1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Cancer Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 40 days
(Specify whether years, months or days) 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Newton
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Route # 1, Lane, Mo
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? — years.

3. (a) PRINT FULL NAME Mr. CARL LAWSON

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Mrs. LOLA LAWSON 6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Dec 2 1915
(Month) (Day) (Year)

8. AGE: Years 26 Months 11 Days 18 If less than one day — hr. — min.

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

10. Usual occupation Training 0

11. Industry or business Laborer 0

12. Name William R. Lawson 0

13. Birthplace Newton Co, Mo.
(City, town or county) (State or foreign country)

14. Maiden name Pattie Bertha Dorris

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

16. (a) Informant Hospital, Records

(b) Address Columbia, Mo.

17. (a) Removal (b) Date thereof Nov. 24, 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Miami, Okla

18. (a) Signature of funeral director Traber's

(b) Address Columbia, Mo

19. (a) 11/23/40 (b) Albie Selby
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 20th
year 1940 hour 7:20 minute 9 M.

21. I hereby certify that I attended the deceased from 10-12, 1940, to 11-20, 1940; that I last saw him alive on 11-20, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Ca of lower lip
Secondary anemia
Due to Emaciation

Due to —
Other conditions (Include pregnancy within 3 months of death) 4⁰

Major findings: Of operations —
Of autopsy None

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? —

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While at work? — (Specify type of place)
(e) Means of injury —
23. Signature Eugene M. Bonicker (M. D. or other) 1 null
Address Ellis Fitchel Cancer Hosp Date signed 11-21-40

Duration —
PHYSICIAN —
Underline the cause to which death should be charged statistically.

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

JUL 17 1945

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. 24132

P. O. Address Chamberlain

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.