DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 7 1941

Registration District No. 784

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32624

Primary Registration District No. 200

Registrar's No. 2019

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town ~~Carondelet~~ Koch
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1408 days (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St.

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

(d) Street No. 1622 Mississippi
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME RAYMOND P. LAWLER

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 Single

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec. (Month) 12 (Day) 1897 (Year)

8. AGE: Years 43 Months 9 Days 19 If less than one day hr. min.

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

10. Usual occupation Clerk

11. Industry or business Railroad

FATHER
12. Name Christopher Lawler
13. Birthplace Ireland (?) (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth Mahon
15. Birthplace St. Louis (City, town, or county) Mo (State or foreign country)

16. (a) Informant Koch Hosp. Records
(b) Address Koch Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4-1941 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J Donnelly
(b) Address 3840 Lindell Blvd

19. (a) OCT 3 - 1941 (Date received local registrar) (b) E. McGuire (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1, year 1941 hour 11:00 minute P M.

21. I hereby certify that I attended the deceased from 11-3-1937 to 10-1-1941; that I last saw him alive on 10-1 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	4½ yr (?)
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

13 N

Major findings:
Of operations
Of autopsy Confirms above

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 B. Friedman (M. D. or other) M D
Address Koch Hosp., Koch, Mo. Date signed 10-2-41

(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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette.

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

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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(a) County St Louis

(b) City or town Koch
(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 1408 da (Specify whether
In this community ~~Life~~ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Raymond P Lawler

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec 12 1897
(Month) (Day) (Year)

8. AGE: Years 43 Months 9 Days 19 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 10-8-41 (Date received local registrar) (b) I G McGavran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
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:
(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 (M. D. or other)
Address Date signed

SUPPLEMENTARY