

FILED APR 13 1942  
Registration District No. 318

Primary Registration District No. 5440

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

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield Rural, Campbell  
(c) Name of hospital or institution: MEDICAL CENTER FOR FEDERAL PRISONERS, 2  
(d) Length of stay: In hospital or institution 1 mo., 22 days.  
In this community 1 mo., 22 days.

2. USUAL RESIDENCE OF DECEASED:

(a) State Ohio (b) County Hamilton  
(c) City or town Cincinnati,  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? No.

3. (a) PRINT FULL NAME LAVIER, Joe

3. (b) If veteran, name war W.W. #1 unverified (c) Social Security No. None

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

6. (b) Name of husband or wife Ethel Patterson 6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased November 25, 1898

8. AGE: Years 43 Months 3 Days 22 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Aurora, Illinois

10. Usual occupation Race track follower

11. Industry or business \_\_\_\_\_

12. Name William Lavier

13. Birthplace Unknown Unknown

14. Maiden name Ingeborg Jensen

15. Birthplace Unknown Denmark

16. (a) Informant Deceased

(b) Address \_\_\_\_\_

17. (a) Removal (b) Date thereof 3/19/42

(c) Place: burial or cremation Earlville, Illinois.

18. (a) Signature of funeral director Thieme

(b) Address Springfield, Missouri

19. (a) 3-19-42 (b) S. W. Dandy

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17, year 1942 hour 5 minute 45 P. M.

21. I hereby certify that I attended the deceased from January 26, 1942, to March 17, 1942, that I last saw him alive on March 17, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary Duration 5 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 13 1/2!

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 Safairery (M. D. \_\_\_\_\_) Address Clinical Director, Medical Center for Federal Prisoners Date signed 3-18-42

**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 *R. H. Christie*

Licensed Embalmer No. 368I

P. O. Address Springfield, 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, fact should be so stated above.**

X