

Registration District No. 170

Primary Registration District No. 5633

Registrar's No. ....

1. PLACE OF DEATH:

- (a) County Laclede  
(b) City or town Rural Smith Township  
(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)

3. (a) PRINT FULL NAME EDWARD DAWSON

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. (M)  
6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased 2 2 1876  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
66 5 22 hr. min.

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

10. Usual occupation Laborer

11. Industry or business

- MOTHER FATHER { 12. Name Unknown  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Social Sec Com  
(b) Address Lebanon

17. (a) Burial (b) Date thereof 7-28-1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Barnett Grave yard

18. (a) Signature of funeral director Virgil Evans

(b) Address Stoutland Mo.

19. (a) Aug-1-42 (b) Grace Roper  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Laclede  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Shelburne RFD 1  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country O

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26  
year 1942 hour minute M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....  
that I last saw him alive on ..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death

Cardiac  
Due to acute alcoholic  
Due to

Other conditions  
(Include pregnancy within 3 months of death)

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 Car  
23. Signature James D. Stautman Coroner  
Address Lebanon Mo. Date signed 7-31-42

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

RECEIVED

*Isabel C. Health Dept.*  
District Health Officer No. ....

District File Number *S-42-123*

Date Filed *S-27-42*

*cor. 09 signed 9* *2* *2*

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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..... *Is*

Licensed Embalmer No. ....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27518

Registration District No. 170

Primary Registration District No. 5633

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: Taclobo Rural  
(a) County \_\_\_\_\_  
(b) City or town \_\_\_\_\_  
(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)

3. (a) PRINT FULL NAME Edward Dawson  
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 Single  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Feb 2  
(Month) (Day) (Year)

8. AGE: Years 66 Months 6 Days \_\_\_\_\_  
(If less than one day \_\_\_\_\_ min.)

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

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

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

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

19. (a) Nov-16-42 (b) Grace Roper  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1942 hour 6 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

