

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42143

State File No.

FILED JAN - 8 1942

Registration District No.

Primary Registration District No. 6086

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall Mo. R.R. #1
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Rural Salt Fork Twp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 months
(Specify whether In this community years, months or days)

3. (a) PRINT FULL NAME

CHARLES LAWRENCE

3. (b) If veteran,

name war ✓

3. (c) Social Security

No. ✓

4. Sex M 5. Color or race Negro 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mary H. Lawrence 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Unknown 1877
(Month) (Day) (Year)

8. AGE: Years 65 Months Days If less than one day
hr. min.

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

10. Usual occupation Janitor

11. Industry or business Apartment

12. Name Sam Lawrence

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

14. Maiden name Harnett Shackelford

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

16. (a) Informant Clarence Lawrence

(b) Address Marshall Mo. R.R. 1

17. (a) Finnish Creek Cem (b) Date thereof 12 8 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Finnish Creek Saline Mo

18. (a) Signature of funeral director J. D. Ferguson

(b) Address Saline Mo

19. (a) Dec 7th 1942 (b) Mrs. W. E. Shackelford
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline
(c) City or town Marshall Mo. R.R. 1
(If outside city or town limits, write "RURAL")
(d) Street No. Salt Fork Twp
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 4th
year 42 hour 1.2 min 00

21. I hereby certify that I attended the deceased from Oct 10 1942 to Dec 4 1942
that I last saw him alive on Oct 10 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Arterial Sclerosis
Duration 4 yrs

Due to

Due to

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: 97
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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury

23. Signature W. E. Shackelford (M.D. or other)

Address Marshall Mo Date signed 12/7/42

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

1-2-43

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 _____

F. D. Ferguson

Licensed Embalmer No. *2172*

P. O. Address *Sedalia*

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.