

Registration District No. **ED APR 28 1943 318**

Primary Registration District No. **1003**

Registrar's No. **3630**

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

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution:
5559 Labadie Ave /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether
years, months or days) **15 yrs.**

In this community.....

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. **5559 Labadie Ave**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Dennis Lawlor**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mary**

6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **June 16th. 1874**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
68	10	1	hr. min.

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

10. Usual occupation **Prison Guard**

11. Industry or business **St. Louis Police Dept.**

MOTHER FATHER

12. Name **John Lawlor**

13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Lawlor**

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

16. (a) Informant **Mrs Mary Lawlor**

(b) Address **5559 Labadie Ave**

17. (a) **Burial** (b) Date thereof **4/21/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cent**

18. (a) Signature **Harrison & Sheahan Und Co**

(b) Address **4415 Washington Blvd.**

19. (a) **APR 10** (b) **J. F. Hendrick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **17th.**
year **1943** hour **1:30 PM** minute..... M.

21. I hereby certify that I attended the deceased from **Nov 1942**
....., 19..... to **4/15**, 19.....
that I last saw him alive on **4/15**, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death **acute dilatation of heart**

Due to **mitral stenosis**

Due to **Rheumatism**

Duration **1 mi**

67

SK

PHYSICIAN

Underline the cause to which death should be charged statistically.

Other conditions (Include pregnancy within 3 months of death) **92**

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) (c) Means of injury **0**

23. Signature **Charles M. Danas** (M. D. or other)

Address **721 Olive - St. Lou** Date signed **4/17/43**

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.....

Esj W Wilkinson

Licensed Embalmer No.....

3575

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.