

S. No. 2
M-2.43
5-17-39
PI X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30798

State File No. _____

FILED OCT 13 1949

Registration District No. 49

Primary Registration District No. 1002

Registrar's No. 4123

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

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

(d) Length of stay: In hospital or institution 11 days
(Specify whether In this community 11 days years, months or days)

3. (a) PRINT FULL NAME Lawrence Infant

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female

5. Color or race W

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

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

7. Birth date of deceased Aug. 20, 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation infant

11. Industry or business _____

MOTHER FATHER {

12. Name Ira Lawrence

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

14. Maiden name Maury Lawrence (M)

15. Birthplace mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address Gen'l Hosp.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Sept 25-43
(Month) (Day) (Year)

(c) Place: burial or cremation Secretary

18. (a) Signature of funeral director Wm A Palmer

(b) Address City mortician

19. (a) 10-1-43 (Date received local registrar)

(b) Dep D. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 5
(If outside city or town limits, write "RURAL") 8

(d) Street No. 1015 Jefferson
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 31
year 1943 hour 5 minute 35 A. M.

21. I hereby certify that I attended the deceased from August 20, 1943, to August 31, 1943
that I last saw her alive on August 31, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Intracranial hemorrhage Duration _____

Due to _____

Due to 83A

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) Manner of injury _____

23. Signature May R. Thom (M. D. or other) _____

Address _____ Date signed _____

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.....

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.