

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6187**
Registrar's No. **725**

FILED FEB 24/1944
Registration District No. **1002**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1114 Bennington
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 22 years
years, months or days)

3. (a) PRINT FULL NAME HERSCHEL WAYNE LAWSON
 3. (b) If veteran, name war. No
 3. (c) Social Security No. No

4. Sex Male 5. Color or Race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Lee
 6. (c) Age of husband or wife if alive 50 years
 7. Birth date of deceased May 11 1886
(Month) (Day) (Year)

8. AGE: Years 57 Months 9 Days 2
 If less than one day _____ hr. _____ min.

9. Birthplace Clarksburg W. Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation Druggist

11. Industry or business _____

MOTHER FATHER
 12. Name L. C. Lawson
 13. Birthplace Clarksburg, W. Va.
(City, town, or county) (State or foreign country)
 14. Maiden name Ida Lawson
 15. Birthplace Clarksburg, W. Va.
(City, town, or county) (State or foreign country)

16. (a) Informant Lee Lawson
 (b) Address 1114 Bennington

17. (a) Burial (b) Date thereof 2/15/1944
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director C. H. Blackman & Son,
 (b) Address Kansas City, Mo.

19. (a) 2-14-44 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")
 (d) Street 1114 Bennington
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Feb. day 13
 year 1944 hour 1 minute 15 P. M.

21. I hereby certify that I attended the deceased from May 1925
 _____, 19____, to Feb, 13th, 1944
 that I last saw him alive on Feb, 12th, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Asthma
 Duration 9 yrs
 Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations none
 Of autopsy none
 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?

23. Signature Herbert R. Rindal (M. D. or other) M.D.
 Address 1102 Grand Ave Date signed 2/14/44
(Specify type of place) (c) Means of injury

10/1/1951

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..... *H. Blackman*

Licensed Embalmer No. *3639*

P. O. Address..... *R. C. 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.