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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 13 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40614

State File No. _____

Registrar's No. 7

Registration District No. 36

Primary Registration District No. 5118

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

1. PLACE OF DEATH:

(a) County BOONE Co.

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

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

(d) Length of stay: 1 in hospital or institution (Specify whether)

In this community Life years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. R.R. 1 Rocheport Mo.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME MRS LULA EVANS LAWRENCE

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE

6. (b) Name of husband or wife _____ 6. (a) Single, widowed, married, divorced WIDOWED

7. Birth date of deceased DEC. 14 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months 0 Days 13 If less than one day hr. _____ min. _____

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

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER { 12. Name JOHN FLAUGHER

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

14. Maiden name SALLIE DANHAM

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

16. (a) Informant Ethel Cook

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

17. (a) REMOVAL (b) Date thereof 12-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WALNUT RIDGE

18. (a) Signature of funeral director C.S. Nunn

(b) Address New Franklin Mo.

19. (a) 1-3-1945 (b) Mrs Betty Crane
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 27 year 1944 hour 5 minute 15 P.M.

21. I hereby certify that I attended the deceased from Feb 13 1941 to Dec 16 1944
that I last saw her alive on Dec 16 1944
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis Duration indefinite

Due to asthma 3 years

Due to 63 C

Other conditions Hypothyroidism
(Include pregnancy within 6 months of death)

Major findings: Of operations none Of autopsy none

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 L. Chamberlain (M. D. or other) Address New Franklin Mo. Date signed 12-29-44

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AUG 7 1945

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..... *W. L. Hall*

Licensed Embalmer No. *3515*

P. O. Address *New Franklin*

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.