

Registration District No. 59

Primary Registration District No. 4097

Registrar's No. 13

1. PLACE OF DEATH
 (a) County Cass
 (b) City or town Harrisonville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. 1
 In this community 55 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Cass
 (c) City or town Harrisonville
 (If outside city or town limits, write "RURAL")
 (d) Street No. 702 E. Pearl
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Sophia Jane Lawson
 3. (b) If veteran, name war ✓
 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan day 12
 year 1945 hour 2 minute 0 M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Jesse B. Lawson
 6. (c) Age of husband or wife if alive 18 years
 7. Birth date of deceased May 18 1856
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 78, 1943, to Jan. 12, 1945
 that I last saw her alive on Jan. 10, 1945, and that death occurred on the date and hour stated above.

8. AGE: Years 88 Months 7 Days 24
 If less than one day _____ hr. _____ min.

Immediate cause of death Cardiac Myasthenia
 Due to Senility
 Due to _____

9. Birthplace Kentucky
 (City, town, or county) (State or foreign country)
 10. Usual occupation Home Maker

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

11. Industry or business _____
 12. Name James Watkins
 13. Birthplace _____
 (City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Mrs. Wray George
 (b) Address Harrisonville Mo
 17. (a) Burial (b) Date thereof Jan. 14, 1945
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Church
 18. (a) Signature of funeral director RUNNENBURGER'S
 (b) Address HARRISONVILLE, MO
 19. (a) Jan. 14, 1945 (b) Margaret Telle
 (Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury: _____
 23. Signature J. S. Triplett (M. D. or other)
 Address Harrisonville Mo. Date signed 1-13-45

Duration _____
PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

2
3
30
37823

MOTHER FATHER

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 Ernest Remmenburger

Licensed Embalmer No. 3368

P. O. Address. Harrisonville 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.

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(a) County Cass
(b) City or town Harrisonville
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(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Sophia J Lawson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 18 1945
(Month) (Day) (Year)

8. AGE: Years 88 Months 7 Days _____ (Unless than one day) _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb year 1945 hour 9:30 minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Chronic Myocarditis

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 J. S. Triplett, M.D. (M.D. or other) _____
Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

S-1945