

No. 17-39 X38671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3861**
Registrar's No. **20**

Registration District No. **300**

Primary Registration District No. **6225**

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

1. PLACE OF DEATH:

(a) County Vernon

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

(c) Name of hospital or institution:
State Hosp No 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2
In this community 1 mo 29 d. (Specify whether years, months or days)

3. (a) PRINT FULL NAME ARTHUR-W^m-LAWLESS

3. (b) If veteran, name war no

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 Amber Lawless

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Sept 11 1880
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>64</u>	<u>4</u>	<u>18</u>	hr. _____ min.

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

10. Usual occupation formerly farmer

11. Industry or business none

MOTHER FATHER

12. Name Patrick Lawless

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

14. Maiden name Orpha Watters

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

16. (a) Informant Records State Hosp 3

(b) Address Nevada, Mo

17. (a) Removal (b) Date thereof 1-29-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope Cemetery

18. (a) Signature of funeral director PARKER-HUNSAKER

(b) Address 1502 Joplin, Moplin, Missouri

19. (a) 1-31-45 (b) Hazel B Bewick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper Mo

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

(d) Street No. 312 - E - 12th St
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 29
year 1945 hour 8 minute A M.

21. I hereby certify that I attended the deceased from Dec 1 1944 to Jan 29 1945
that I last saw him alive on Jan 29 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-vascular-renal disease

Due to hypertension + arteriosclerosis

Due to _____

Other conditions With psychosis
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations no

Of autopsy no

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) no

(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 Paul L Barvie (M. D. or other)

Address State Hosp No 3 Date signed Jan 29

1331

Nevada 1945

Missouri State Board of Health
Division of Health
Deceased File Number 1-45-20
New Filed 2-5-43

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 F M Jones
Licensed Embalmer No. 2319
P. O. Address Joplin 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.

Registration District No. 360

Primary Registration District No. 6225

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Rural Washington Twp
(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 _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

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 _____

3. (a) PRINT FULL NAME Arthur Wm Lawrence

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Sept 11
(Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days _____ If less 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 9 Year 1955 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

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) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

3861