

FILED MAR 30 1945

Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(c) Name of hospital or institution **Springfield Baptist Hospital**
(d) Length of stay: In hospital or institution _____
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**
(c) City or town **Walnut Grove R. 3**
(d) Street No. _____
(e) Citizen of foreign country? _____

3. (a) PRINT FULL NAME **Don H. Lawrence**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Clara Ann Lawrence** 6. (c) Age of husband or wife if alive **58** years

7. Birth date of deceased **January 12, 1884**

8. AGE: Years **61** Months **1** Days **20** If less than one day _____ hr. _____ min.

9. Birthplace **Jacks County Mo.**

10. Usual occupation **farmer & thresherman**

11. Industry or business **Stock farmer Threshing grain**

12. Name **Walter C. Lawrence**

13. Birthplace **UNK. Missouri**

14. Maiden name **Carla Bailey**

15. Birthplace **UNK. Mo.**

16. (a) Informant **Clara Lawrence**

(b) Address **Walnut Grove, Mo.**

17. (a) **Burial** (b) Date thereof **March 4, 1945**

(c) Place: burial or cremation **Greenbary Cemetery**

18. (a) Signature of funeral director **Gene H. Brown**

(b) Address **Walnut Grove, Mo.**

19. (a) **3-3-45** (b) **W. H. Handley**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **2nd** year **1945** hour **6** minute **45 a.m.**

21. I hereby certify that I attended the deceased from **2/27** 19**45** to **3/2** 19**45**

that I last saw him alive on **3/1** 19**45** and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia**

Due to **Cardiovascular renal disease**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____

23. Signature **W. H. Handley** (M. D. or other) **MD**

Address **Springfield, Mo.** Date signed **3/3/45**

Duration

5d.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Gene A. Brown*

Licensed Embalmer No..... *2064*

P. O. Address..... *Gene A. Brown*

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. 125

Primary Registration District No. 2000

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

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(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

3. (a) PRINT FULL NAME Don H. 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 _____ years

7. Birth date of deceased Jan 12 (Month) (Day) (Year)

8. AGE: Years 61 Months 1 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 _____ (Month) (Day) (Year)

(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 mar day _____ year 1945 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 _____

Chronic Nephritis
Due to which followed a long
Due to standing hypertension
Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____

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 Guy Hallaway (M. D. or other) _____
Address Springfield, Mo Date signed _____

SUPPLEMENTARY

