

FILED JAN 11 1945

Registration District No. 110

Primary Registration District No. 4182

Registrar's No. 5

1. PLACE OF DEATH:

(a) County: Franklin
(b) City or town: Newelltown Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1-17-45
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: all (Specify whether years, months or days)

3. (a) PRINT FULL NAME: WILLIAM F. LAWSON

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

4. Sex: MALE 5. Color or race: W 6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Mary Lawson 6. (c) Age of husband or wife if alive: 59 years
7. Birth date of deceased: Aug 6 1887 (Month) (Day) (Year)

8. AGE: Years: 58 Months: 4 Days: 11 If less than one day hr. min.

9. Birthplace: Gasconade County Mo. (City, town, or county) (State or foreign country)

10. Usual occupation: Rail Road

11. Industry or business:

MOTHER FATHER
12. Name: Mathew Lawson
13. Birthplace: Gasconade County Mo.
14. Maiden name: Mancy Kestler
15. Birthplace: Gasconade County Mo.

16. (a) Informant: Geo Lawson
(b) Address: Newelltown Mo.

17. (a) Burial (b) Date thereof: 12-20-45
(Burial, cremation, or funeral) (Month) (Day) (Year)

(c) Place: burial or cremation: Newelltown Mo.

18. (a) Signature of funeral director: W. H. ...
(b) Address: Newelltown Mo.

19. (a) Dec 20-45 (b) Jessie A. Gramm
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Franklin
(c) City or town: Newelltown Mo. (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: Dec. day: 17
year: 1945 hour: 9:30 minute: P. M.

21. I hereby certify that I attended the deceased from Dec. 30, 1943 to Dec. 17, 1945; that I last saw him alive on Dec. 15, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death: Mitral Incompetency and Stenosis (Rheumatic) Duration: CHRONIC

Due to:

Due to:

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations: AK
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?

(Specify type of place) While at work? (e) Means of injury: 2

23. Signature: W. H. ... (M. D. or other) D.O.
Address: New Haven, Mo. Date signed: 12/19/45

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

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 3-10-46

MAY 22 1950

MAR 14 1946

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 Earl Jesty
Licensed Embalmer No. 3385
P. O. Address York Haven Pa

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.