

S. No. 2  
M-542  
7-5-17-39  
-1 X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23303

FILED AUG 13 1946

State File No. \_\_\_\_\_  
Registrar's No. 610

Registration District No. 128

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, MO.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST. JOHN'S HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 36 HRS.  
(Specify whether years, months or days) 8 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. 1885 W Douglas ave.  
(If rural, give location)

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

3. (a) PRINT FULL NAME BABY LAWSON

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife NONE

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

7. Birth date of deceased: 7 - 20 - 46  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 20<sup>th</sup>  
year 46 hour 12:00 minute 0 M.

21. I hereby certify that I attended the deceased from 7-20-46  
to 7-20-46  
that I last saw him alive on 12:13 am 7-20 1946  
and that death occurred on the date and hour stated above.

| 8. AGE: | Years    | Months   | Days     | If less than one day |
|---------|----------|----------|----------|----------------------|
|         | <u>0</u> | <u>0</u> | <u>0</u> | <u>5</u> min.        |

Immediate cause of death: Prematurity

Due to Premature Labor

Due to 5 1/2 mo gestation

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace ST. JOHN'S HOSPITAL Springfield MO  
(City or town, county, state or foreign country)

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name WILLIAM PAUL LAWSON

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

14. Maiden name BILLIE WEBB

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

16. (a) Informant Paul Lawson

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 7-21-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greentown

18. (a) Signature of funeral director W. L. Johnston

(b) Address Springfield, Mo.

19. (a) 7-23-46 (b) S. W. Handley  
(Date received local registrar) (Registrar's signature)

Major findings: Of operations \_\_\_\_\_

Of autopsy 159

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 W. L. Johnston (M. D. or other) \_\_\_\_\_  
Address Springfield, Mo. Date signed 7-23-46

Duration \_\_\_\_\_

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.

*Not embalmed*

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

X