DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 24 1947

Registration District No. 0

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13025

Primary Registration District No. 3019

Registrar's No. 171

1. PLACE OF DEATH:

(a) County: DUNKLIN

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

(c) Name of hospital or institution: PRESNELL HOSPITAL 0 (If not in hospital or institution, write street number or location)

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

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: DUNKLIN 35

(c) City or town: KENNETT MO RT. 1 0 (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: MABLE FRANCIS LAWSON

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex: FEMALE

5. Color or race: WHITE

6. (a) Single, widowed, married, divorced: MIV

6. (b) Name of husband or wife .....

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

7. Birth date of deceased: DEC. (Month) 17 (Day) 1919 (Year)

8. AGE: Years 26 Months 3 Days 20 If less than one day ..... hr. ..... min.

9. Birthplace: PONTOC (City, town, or county) MISS. (State or foreign country)

10. Usual occupation: HOUSE WIFE

11. Industry or business .....

MOTHER FATHER

12. Name: S. G. KENNEDY

13. Birthplace: PONTOC (City, town, or county) MISS. (State or foreign country)

14. Maiden name: ANNIE DENTON

15. Birthplace: PONTOC (City, town, or county) MISS. (State or foreign country)

16. (a) Informant: J. C. LAWSON

(b) Address: KENNETT MO. RT. 1.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: APR. 8-47 (Month) (Day) (Year)

(c) Place: burial or cremation: OAK RIDGE

18. (a) Signature of funeral director: LENTZ SERVICE

(b) Address: KENNETT

19. (a) 4-15-1947 (Date received local registrar) (b) Earl Hubbard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 7TH year 1947 hour 11 minute 40 A. M.

21. I hereby certify that I attended the deceased from 4-4-47, 19..., to 4-7, 1947 that I last saw her alive on 4-7, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Eclampsia	
Post-partum	
Due to:	
Due to: 148 A	
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? (Specify type of place)

While at work? (e) Means of injury: 0

23. Signature: L. C. Wilson (M. D. or other)

Address: Kennett Mo Date signed: 4-10-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No.
District File Number 442-6
Date Filed 4-22-

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. ____

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. ____

1. PLACE OF DEATH:

(a) County: Dunklin

(b) City or town: Kennett
(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 years, months or days)
In this community ____

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: Mable F. 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: M

6. (b) Name of husband or wife: J. C. Lawson

6. (c) Age of husband or wife if alive: 38 years

7. Birth date of deceased: Dec (Month) 17 (Day) 1918 (Year)

8. AGE: Years 26 Months 3 Days ____ If less than one day ____ hr. ____ min.

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

10. Usual occupation ____

11. Industry or business ____

MOTHER FATHER

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) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)

(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____

(b) Address ____

19. (a) ____ (Date received local registrar) (b) Earl Husband (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ____ Day 7 year 1947 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h____ 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.

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(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 ____

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

Address ____ Date signed ____

SUPPLEMENTARY

13025