

S. No. 2
DM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 29 1947
149

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17503
Registrar's No. 2259

Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
709 Washington
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Do not know years, months or days

3. (a) PRINT FULL NAME Frank Lawler
(b) If veteran, name was do not know
(c) Social Security No. -----

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Do not know

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

7. Birth date of deceased: 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 hr. min.

9. Birthplace Do not know
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Do not know

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

14. Maiden name Do not know

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

16. (a) Informant Coroner Office

(b) Address Kansas City MO

17. (a) School (b) Date thereof 5/23/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation K.C. College of Osteopathy & Surgery

18. (a) Signature of funeral director Passantino Bros

(b) Address Kansas City Mo

19. (a) 5-23-47 (b) Sheldine Holmes
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 709 Washington
(If rural, give location)
(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19
year 1947 hour 4 minute 45 a M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____,
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary Sclerosis
Due to _____
Due to _____

Other conditions _____
(Include coronary within 3 months of death)
Repetitive Coronary

Major findings:
Of operations _____
Of autopsy History & inspection

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) Means of injury _____

23. Signature W. E. Upcher (M. D. or D. O.)
Address 2800 Mun Date signed 5/27/47

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.

Signed *J. S. Walton*

ES Licensed Embalmer No. *2744*

P. O. Address *K.C. 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.