No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19072

FILED JUN 13 1947 #70355

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5473

1. PLACE OF DEATH:

(a) County

(b) City or town St.Louis,Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St.Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution premature (Specify whether
In this community 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0 0 0 13

(c) City or town St.Louis 9
(If outside city or town limits, write "RURAL")

(d) Street No. 2312 S. 10th 0
(If rural, give location)

Memorial 23

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

If yes, name country

3. (a) PRINT FULL NAME NORMA JEAN LAWTON

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex female 1

5. Color or race white

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased April 15th,1947
(Month) (Day) (Year)

8. AGE: Years | Months | Days 16 | If less than one day
~~18days~~ hr. min.

9. Birthplace St.Louis City Hospital 0
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business

FATHER
12. Name Louis Lawton
13. Birthplace Kentucky 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Pearl Mabe
15. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

16. (a) Informant M.Renard
(b) Address St.Louis City Hospital.

17. (a) Anatomical Board (b) Date there 5-8-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director W. Richter
(b) Address 3500 Rutger St

19. (a) JUN 2 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1st
year 1947 hour 10:25 minute P M.

21. I hereby certify that I attended the deceased from 4/15/47
, 19, to April 1st, 1947
that I last saw her alive on April 1st, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Aspiration of Vomitous

Due to Premature Infant

Due to Diarrhea of undetermined cause, mild

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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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 S. Gollub (M. D. or other)

Address 1515 Lafayette Date signed 5/2/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 with the above constitutes grounds for revocation of license.)

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