S. No. 2
—12-45
5-17-39
P I X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 20 1947

Registration District No. 128

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

State File No. 27375

Registrar's No. 683

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: Burge Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 25 hrs 20 min Nsg (Specify whether)

In this community yes
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

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

(d) Street No. 2025 N Johnston
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Keith Clayton, Lawing

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race WHITE

6. (a) Single, widowed, married, divorced single no

6. (b) Name of husband or wife no

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

7. Birth date of deceased July (Month) 30 (Day) 47 (Year)

8. AGE: Years | Months | Days 2 | If less than one day 25 hr. 20 min.

9. Birthplace Burge Hosp Springfield (City, town, or county) Mo (State or foreign country)

10. Usual occupation — Infant

11. Industry or business — at home

FATHER
12. Name Clayton O Lawing
13. Birthplace West plains (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Kathleene Keith
15. Birthplace (Missouri) Aurora (City, town, or county) Mo (State or foreign country)

16. (a) Informant Clayton O Lawing
(b) Address 2025 N Johnston

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof August, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director J W Klingner & Co.
(b) Address Springfield Mo.

19. (a) 8-1-47 (Date received local registrar) (b) W E Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31 year 1947 hour 6:05 minute P. M.

21. I hereby certify that I attended the deceased from July 30, 1947, to July 31, 1947; that I last saw him alive on July 31, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity — Duration Life

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.

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

23. Signature Thomas S. Harris (M. D. or other) MD

Address Medical Arts Bldg Springfield, Missouri Date signed 7/31/47

(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.

No Embalming

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.