

S. No. 2
M-5-43
7-5-17-39
0 1 (X3087)

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43963**

FILED DEC 31 1947

Registration District No. **270**

Primary Registration District No. **6151**

Registrar's No. **34**

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

1. PLACE OF DEATH:
 (a) County Stoddard
 (b) City or town Rural (Ck)
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
(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) 34 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Stoddard 103
 (c) City or town Rural 0
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location) 10
 (e) Citizen of foreign country? _____ (Yes or No) 0
 If yes, name country _____

3. (a) PRINT FULL NAME "Largy" Amanda Lawrence
 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 Widow
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 11 6 1865
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 12 day 16
 year 1947 hour 2 minute P M.
 21. I hereby certify that I attended the deceased from 11-3-47, 19____, to 12-16-47, 19____;
 that I last saw him alive on 12-13-47, 19____;
 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>82</u>	<u>1</u>	<u>10</u>	hr. <u>—</u> min. <u>—</u>

Immediate cause of death _____
Cerebral Hemorrhage
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____
 Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

9. Birthplace Golden Pond Ny 1
(City, town, or county) (State or foreign country)
 10. Usual occupation House Work (Home)
 11. Industry or business _____
 12. Name Jerhuay Hudson
 13. Birthplace _____
(City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
(City, town, or county) (State or foreign country)

MOTHER FATHER
 16. (a) Informant Willbert Lawrence
 (b) Address Parma Mo R1
 17. (a) Burial (b) Date thereof 12-17-47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Stanton Cemetery
 18. (a) Signature of funeral director Thomas C Knight
 (b) Address Parma Mo
 19. (a) 12-23-47 (b) Lottie J Press
(Date received local registrar) (Registrar's signature) 357

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 J H Gelber (M. D. or other) MD
 Address Parma Mo Date signed 12/20/47

RECEIVED

Health Office No. 2,
District File Number 1247-1638
Date Filed 12-29-47

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.....

Wallace R. Knight....., Registered Apprentice No. 482
working under my personal supervision.

Signed Thomas E. Knight.....

Licensed Embalmer No. 2189.....

P. O. Address Parma, 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.