

S. No. 2  
-12-45  
-17-39  
X47070

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 247

FILED FEB 3 1948

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 81

1. PLACE OF DEATH

(a) County St. Louis  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital # 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 19 yrs 8 mos 3 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Andrew  
(c) City or town Roller  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Arthur Lawrence

3. (b) If veteran, name war no  
3. (c) Social Security No. nil

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Mary  
6. (c) Age of husband or wife if alive Not given years  
7. Birth date of deceased unknown 1881  
(Month) (Day) (Year)

8. AGE: Years 66 Months ? Days ?  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Farming, tree gardening

11. Industry or business at his home

12. Name George Lawrence

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

14. Maiden name Mary Green

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

16. (a) Informant Sam Lawrence

(b) Address Roller Mo

17. (a) burial (b) Date thereof 1-25-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savannah Mo

18. (a) Signature of funeral director E.C. Breech

(b) Address Savannah Mo

19. (a) 1-24-48 (b) to the Registrar  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 27  
year 1948 hour 5 minute 50 P.

21. I hereby certify that I attended the deceased from 1-27, 1948 to 1-27, 1948  
that I last saw him alive on 1-27, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 1 day  
and probably brain hemorrhage  
the first 1928, 2d brain trouble today  
could not think, which side  
Due to hypertension blood pressure 200/120 in 1928

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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) (b) Means of injury \_\_\_\_\_

23. Signature [Signature] (b) [Signature]  
Address State Hospital # 2, St. Joseph Mo Date signed 1/22/1948

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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**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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah Ga

**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.**