

S. No. 2  
1-1/47  
5-17-39

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **16175**

National Office of Vital Statistics

FILED JUN 1 1948

Registration District No. **171**

Primary Registration District No. **5550**

Registrar's No. **34**

1. PLACE OF DEATH:

(a) County ~~Howell~~ **HOWELL**

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

(c) Name of hospital or institution: **RFD 4**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution, **entire life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Howell**

(c) City or town **Carroll, Mo**  
(If outside city or town limits, write "RURAL")

(d) Street No. **R. F. D.** (If rural, give location)

(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **Wm Ambrose Lawing**

3. (b) If veteran,  name war

3. (c) Social Security No. **1-16-1872**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **3** year **1948** hour **1** minute **A-M**

21. I hereby certify that I attended the deceased from **4-3** 19**47** to **3-3** 19**48**  
that I last saw **h.l.m.** alive on **Feb. 20** 19**48**  
and that death occurred on the date and hour stated above.

4. Sex **mo** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife **Missouri E. Lawing** 6. (c) Age of husband or wife if alive **53** years

7. Birth date of deceased **9-16-1872**  
(Month) (Day) (Year)

Immediate cause of death **acute distention of heart**  
**Chronic Myocarditis**  
**Essential Hypertension**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: **972**  
Of operations

Of autopsy

PHYSICIAN **J. De Pans**  
Underline the cause of which death should be charged statistically.

8. AGE: Years **75** Months **5** Days **17** If less than one day hr. min.

9. Birthplace **Howell Co., Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

MOTHER FATHER

11. Industry or business

12. Name **Jack Lawing**

13. Birthplace **N. Carolina**  
(City, town, or county) (State or foreign country)

14. Maiden name **Robertson**

15. Birthplace **N. Carolina**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Missouri E. Lawing**

(b) Address **Carroll, Mo**

17. (a) **3** (b) Date thereof **3-5-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cypress**

18. (a) Signature of funeral director **Robertson**

(b) Address **West Plains, Mo**

19. (a) **May 11-48** (b) **Beatrice Cook**  
(Date received local registrar) (Registrar's signature)

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 **J. De Pans** (M. D. or other)

Address **Carroll, Mo.** Date signed **3-15-48**

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

**J. De Pans**

RECEIVED  
District Health Officer No. 8,  
District File Number 548346  
Date Filed 5-27-47

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 Robert J. Prager, Registered Apprentice No. 437 working under my personal supervision.

Signed A. S. Roberts

Licensed Embalmer No. 3437  
P. O. Address West Hill, N.Y.

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.