

S. No. 300
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 7 1948
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4954**

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution **City Sanitarium** **0**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1yr 1mo 18das**
(Specify whether years, months or days)

In this community **26 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**

(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")

(d) Street No. **4305 W. Pine St** **9**
(If rural, give location)

(e) Citizen of foreign country? **No** **0**
(Yes or No)

If yes, name country **No**

3. (a) PRINT FULL NAME **JACK LAWHORN**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **19th**
year **1948** hour **7:00** minute **P.** M.

4. Sex **male** **0**

5. Color of race **White**

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **May 18, 1882**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **July 1, 1947** to **May 19, 1948**
that I last saw him alive on **May 19, 1948**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
66yrs 00da. 1da. hr. _____ min.

Immediate cause of death

Bronchial Pneumonia **3 das.**

Hypertensive Heart Disease **1947x.**

Due to _____

Due to _____

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

10. Usual occupation **R. R. Switchman**

Other conditions **93**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy **No.**

11. Industry or business _____

12. Name **not known**

13. Birthplace **not known** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **not known**

15. Birthplace **not known** **9**
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant **City Sanitarium Records**

(b) Address **5400 Arsenal St**

17. (a) **Anatomical Board** (b) Date thereof **MAY 31 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Anatomical Board**

18. (a) Signature of funeral director **Richard Mortuary Service**

(b) Address **4104 Manchester Ave.**

19. (a) **MAY 31 1948** (b) **J. F. Bredack**
(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? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature **W. H. Hamey R. R.** (M. D. or other) **0**

Address **5400 Arsenal St** Date signed **5/20/48**

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

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 Ralph W Henson
Licensed Embalmer No. 3791
P. O. Address St. Louis, 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.