

FILED NOV 10 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35759

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 6076		Registrar's No. 2427	
1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) Koch (rural)		c. LENGTH OF STAY (in this place) 206 days		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital				d. STREET ADDRESS (If rural, give location) 3670 Finney			
3. NAME OF DECEASED (Type or Print) a. (First) Henry		b. (Middle) -		c. (Last) Lawrence		4. DATE OF DEATH (Month) (Day) (Year) October 6, 1950	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH 3-28-04	
9. AGE (In years last birthday) 46		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		11. BIRTHPLACE (State or foreign country) Greenwood, Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Thomas Lawrence		13b. MOTHER'S MAIDEN NAME Alice Brown		14. NAME OF HUSBAND OR WIFE Rexola Ford (divorced)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ??		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hospital Records, Robt. Koch Hospital			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Osteomyelitis of distal end of left femur Conditions contributing to the death but not related to the disease or condition causing death. 19a. DATE OF OPERATION _____					
19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				0027	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				22. I hereby certify that I attended the deceased from 3-14-50, 19, to 10-6-50, 19, that I last saw the deceased alive on 10-6-50, 19, and that death occurred at 7 P. m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) John Niederwieser, M.D.		23b. ADDRESS Koch, Mo		23c. DATE SIGNED 10-7-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-11-50		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo	
DATE REC'D BY LOCAL REG. 10-10-50		REGISTRAR'S SIGNATURE Herbert R Danke		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 3644 Finney			

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

PWR (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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Louis V. Atkins*

Licensed Embalmer No. 2842

P. O. Address. 3644 Finney

**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.