

FILED SEP 17 1951

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29988

787

BIRTH NO. _____		REG. DIST. NO. 126		PRIMARY REG. DIST. NO. 2000		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Polk			
b. CITY (If outside corporate limits, write RURAL and give town) Springfield		c. LENGTH OF STAY (in this place) 3 days		c. CITY (If outside corporate limits, write RURAL and give township) Flemington Mo. 11840			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION OSZARK OSTEOPATHIC INSTITUTE				d. STREET ADDRESS (If rural, give location) Flemington, Mo. 1			
3. NAME OF DECEASED (Type or Print) a. (First) Wealtha		b. (Middle)		c. (Last) Lawson		4. DATE OF DEATH (Month) (Day) (Year) Sept. 11, 1951	
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) Married	8. DATE OF BIRTH 4/2/1890		9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months 5 Days 9	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Osceola, Polk Co., Neb.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME William Oscar Cox		13b. MOTHER'S MAIDEN NAME Maryette Gierhart		14. NAME OF HUSBAND OR WIFE Harrison M. Lawson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NUMBER Has number No. unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Harrison M. Lawson, Flemington, Mo.			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gun shot wound in left chest ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Internal hemorrhage DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		E976X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Farm		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Flemington, Polk, Mo			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 9/8/51 10:00am		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Shot self			
22. I hereby certify that I attended the deceased from 9/8 , 19 51 , to 9/11 , 19 51 , that I last saw the deceased alive on 9/10 , 19 51 , and that death occurred at 4:46P m., from the causes and on the date stated above.							
23a. SIGNATURE W. E. Sandby, D.O. (Degree or title)				23b. ADDRESS 2 Humansville, Mo.		23c. DATE SIGNED 9/10/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-14-51		24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		24d. LOCATION (City, town, or county) (State) Springfield Mo.	
DATE REC'D BY LOCAL REG. 9-13-51		REGISTRAR'S SIGNATURE W. E. Sandby M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. W. Klingner Co. Springfield Mo.			

(Licensed Embalmer's Statement on Reverse Side)

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

OCT 13 1961

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 _____

working under my personal supervision.

Student Embalmer No. _____

Student
Student Embalmer

Signed *Max Rhodes* _____

Licensed Embalmer No. *4071* _____

P. O. Address *Spring Hill* _____

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.