

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 24 1951

BIRTH NO. _____ REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 5726 Registrar's No. 105

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived, in institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Middle Fort</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Middle Fort</u>	
c. LENGTH OF STAY (in this place) <u>27 years</u>		d. STREET ADDRESS (If rural, give location) <u>R.F.D. #3 Jacksonville</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN BUTLER LAWRENCE</u> b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct-8-1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec-12-1886</u>
9. AGE (in years last birthday) <u>64</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>New Florence MO.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Marion Lawrence</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Silver's</u>	14. NAME OF HUSBAND OR WIFE <u>Hellie B. Lawrence</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>498-09-8461</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. John Lawrence Jacksonville</u> ADDRESS _____
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) <u>Hypostatic pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> ANTECEDENT CAUSES DUE TO (b) <u>Carcinoma of Prostate</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS 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 checked="" type="checkbox"/>
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) (Min.) _____	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 <u>1949</u> to <u>Oct 8</u> , 1951, that I last saw the deceased alive on <u>Oct 8</u> , 1951, and that death occurred at <u>8:00 A</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Dr. H. Mc Cormick D.O.</u>		23b. ADDRESS <u>306 1/2 Reed St. Moberly Mo.</u>	23c. DATE SIGNED <u>10-9-51</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct-10-1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Salem Cemetery</u>	24d. LOCATION (City/town, or county) (State) <u>Macon Co. Mo.</u>
DATE REC'D BY LOCAL REG. <u>10/13/51</u>	REGISTRAR'S SIGNATURE <u>Ruth Mcneely</u>	FUNERAL DIRECTOR'S SIGNATURE <u>Snow Funeral Home</u>	ADDRESS <u>Moberly Mo.</u>

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

10.22.51
RECEIVED
MACON COUNTY HEALTH DEPARTMENT
County File No. 1051173
Date Filed 10.22.51

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 R. M. Carter

Licensed Embalmer No. 4117

P. O. Address Maoberly 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.