

FILED NOV 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35325**

Registrar's No. **9281**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1006**

1. PLACE OF DEATH a. COUNTY		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 township) OR St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		22. STREET ADDRESS (If rural, give location) 1431 Chouteau Ave.	

3. NAME OF DECEASED (Type or Print) ROBERT LAWSON			4. DATE OF DEATH (Month) (Day) (Year) OCT. 21 1951		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 5, 1898		9. AGE (In years, months, days) 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) St. Charles, Mo.	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME John Lawson		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Ruth		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 497-01-5210	

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Robert Lawson Jr. 1717 Ohio, St. Louis, 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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 day
	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 Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive cardiovascular disease 7 years			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION disease.	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 321X

22. I hereby certify that I attended the deceased from **10-21-51**, 19____, to **10-21-51**, 19____, that I last saw the deceased alive on **10-21-51**, 19____, and that death occurred at **8:40 A m.**, from the causes and on the date stated above.

23a. SIGNATURE John T. Lawson, M.D.		23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 10-22-51
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 10-24-51	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope	24d. LOCATION (City, town, or county) (State) St. Louis co. Mo.	

DATE REC'D BY LOCAL REG. 61 22 1951	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin Funeral Home, Inc. St. Louis, Mo.
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WRITE PLAINLY—USING 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 _____
working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed *L.P. Cooper*

Licensed Embalmer No. *3653*

P. O. Address *2317 Lafayette*

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.