

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33620**
9420

FILED **OCT 15 1953**

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Registrar's No. **9420**

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
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 TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 27 3321 Laclede Ave;				
3. NAME OF DECEASED (Type or Print) a. (First) MABEL		b. (Middle) LAWRENCE		c. (Last) LOYD		4. DATE OF DEATH (Month) (Day) (Year) Sept. 29 1953		
5. SEX Female 3		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 14, 1931		
9. AGE (In years last birthday) 22		IF UNDER 1 YEAR Months 3 Days 14		IF UNDER 24 HRS. Hours _____ Mins. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Little Rock, Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME George Lawrence			13b. MOTHER'S MAIDEN NAME Nerry Russell			14. NAME OF HUSBAND OR WIFE Richard Lloyd		
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 NO. _____		17. INFORMANT'S SIGNATURE OR NAME Willie Mae Franklin ADDRESS 3312 Bell Ave.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) Pulmonary Oedema DUE TO (c) Cardiac Hypertrophy II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					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? 4343				
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred on 8:30 A.M. , from the causes and on the date stated above.								
23a. SIGNATURE (In case of child, _____) <i>John T. Quinn</i>				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 10/1/53		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct. 1, 1953		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) Little Rock, Arkansas		
DATE RECD BY LOCAL REG. OCT 1 1953		REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i>		25. FUNERAL DIRECTOR'S SIGNATURE J. H. RANDLE & SON ADDRESS 3133 Bell Ave.				

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *S. J. Watson*
Licensed Embalmer No. *2691*
P. O. Address *2769 W. 4th*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.