

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11720**

FILED MAY 9 1955

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3625 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY Howell		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howell	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN West Plains		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN West Plains	
c. LENGTH OF STAY (In this place) 8 months		d. STREET ADDRESS (If rural, give location) 0 4 1/2	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) Rosa	b. (Middle) Lee	c. (Last) Lawson	4. DATE OF DEATH (Month) (Day) (Year) April 16, 1955
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 5-14-1875	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months 11 Days 2	IF UNDER 4 HRS. Hours Min.
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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) Couch, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Lindley Couch	13b. MOTHER'S MAIDEN NAME Sarah Kilman	14. NAME OF HUSBAND OR WIFE Oscar Lawson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema		3 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congestive Heart Failure DUE TO (c) Hypertensive Cardiovascular		1 year 10 years
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 443 X	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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
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22. I hereby certify that I attended the deceased from August, 1954, to April 16, 1955, that I last saw the deceased alive on April 14, 1955, and that death occurred at 6:52 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. S. Smiler M.D.	23b. ADDRESS 914 W. Broadway West Plains	23c. DATE SIGNED 4/26/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-18-1955	24c. NAME OF CEMETERY OR CREMATORY New Salem Cemetery	24d. LOCATION (City, town, or county) (State) Couch Oregon Missouri
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DATE REC'D BY LOCAL REG. 5-5-55	REGISTRAR'S SIGNATURE Beatrice Cook	25. FUNERAL DIRECTOR'S SIGNATURE Shayne Nes	ADDRESS
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JUN 24 1955

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 _____

Licensed Embalmer No. 45-16

P. O. Address Rayon m

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.