

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 2 1955

State File No. **38515**  
Registrar's No. **10185**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY _____  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>b. STATE <b>Missouri</b> b. COUNTY _____ |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> |  | c. CITY OR TOWN <b>St. Louis</b>   |  |
| c. LENGTH OF STAY (in this place) <b>12 Yrs.</b>  |  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>6336 Mardel Ave.</b>                               |  | e. STREET ADDRESS (If rural, give location) <b>14 6336 Mardel Ave.</b>   |  |

|                                     |                         |                       |                           |                                       |                     |
|-------------------------------------|-------------------------|-----------------------|---------------------------|---------------------------------------|---------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>Ollie</b> | b. (Middle) <b>D.</b> | c. (Last) <b>Lawrence</b> | 4. DATE OF DEATH (Month) (Day) (Year) | <b>Nov. 21 1955</b> |
|-------------------------------------|-------------------------|-----------------------|---------------------------|---------------------------------------|---------------------|

|                 |                           |   |                                       |   |   |  |
|-----------------|---------------------------|---|---------------------------------------|---|---|--|
| 5. SEX <b>M</b> | 6. COLOR OR RACE <b>W</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b> | 8. DATE OF BIRTH <b>Aug. 17, 1881</b> | 9. AGE (In years last birthday) <b>74</b> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Mins. _____ |
|-----------------|---------------------------|---|---------------------------------------|---|---|--|

|  |   |   |  |
|--|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>Taxi Cab</b> | 11. BIRTHPLACE (City and State or Foreign Country) <b>Water Valley, Ky.</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
|--|---|---|--|

|   |  |   |
|---|--|---|
| 13a. FATHER'S NAME <b>Archie Lawrence</b> | 13b. MOTHER'S MAIDEN NAME <b>Alice Crowder</b> | 14. NAME OF HUSBAND OR WIFE <b>Dora M. Lawrence</b> |
|---|--|---|

|  |  |   |                            |
|--|--|---|----------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> | 16. SOCIAL SECURITY NO. <b>492-30-1955</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>Dora M. Lawrence</b> | ADDRESS <b>6336 Mardel</b> |
|--|--|---|----------------------------|

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 mo</b><br><br><b>2 yrs.</b> |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Stemnia</b>  |  |  |
|  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Cardio vascular renal syndrome</b><br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |

|                              |  |  |
|------------------------------|--|--|
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION <b>442x</b> | 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) _____ | 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 **1944 to 11-21**, 19**55** that I last saw the deceased alive on **11-20**, 19**55**, and that death occurred at **9:30A** m., from the causes and on the date stated above.

|   |                               |   |                                  |
|---|-------------------------------|---|----------------------------------|
| 23a. SIGNATURE <b>J.D. Michael M.D.</b> | (Degree or title) <b>M.D.</b> | 23b. ADDRESS <b>812 Olive St. Louis</b> | 23c. DATE SIGNED <b>11-22-55</b> |
|---|-------------------------------|---|----------------------------------|

|  |                             |  |  |
|--|-----------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> | 24b. DATE <b>Nov. 23-55</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b> | 24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b> |
|--|-----------------------------|--|--|

|   |   |  |  |
|---|---|--|--|
| DATE REC'D BY LOCAL REG. <b>NOV 22 1955</b> | REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Holmeister Colonial Mortuary</b> | ADDRESS <b>6464 Chippewa St., St. Louis, Mo.</b> |
|---|---|--|--|

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

Dec 1-4004

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 *Louis C. Hoffmann*

Licensed Embalmer No. 38

P. O. Address 7814 S

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.