

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15955

STATE FILE NUMBER

FILED APR 30 1957

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 78

S. 300
1-56

securing the medical certification in the specific manner required by 193.140 R.S.M.S. 1943.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <i>Vernon</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Howell</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Washington Township</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <i>West Plains, Mo.</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b HOSPITAL OR INSTITUTION <i>State Hospital #3 1 yr 5 mo</i>				d. STREET ADDRESS <i>307 Worcester</i> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>LAWSON</i> First Middle Last			4. DATE OF DEATH Month Day Year <i>4 24 1957</i>				
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 18, 1883</i>		9. AGE (In years last birthday) <i>73</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming & labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming & labor</i>		11. BIRTHPLACE (City and state or country) <i>Penn</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Haley</i>				14. MOTHER'S MAIDEN NAME <i>Lue Eckord</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Year, no. or unknown) (If yes, give war or date of service) <i>unknown</i>		16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT <i>Hospital Records</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i>						INTERVAL BETWEEN ONSET AND DEATH <i>Yrs.</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Generalized Arteriosclerosis</i>						<i>Yrs.</i>	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. <i>None</i>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <i>Dec 31, 1956</i> to <i>April 24, 1957</i> and last saw her alive on <i>Apr 24, 1957</i> Death occurred at <i>8:30 p</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>George Esker, M.D.</i>				22b. ADDRESS <i>State Hospital #3</i>		22c. DATE SIGNED <i>4/24/57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>April 25 1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sweetain</i>		23d. LOCATION (City, town, or county) (State) <i>Dora Missouri</i>		
24. FUNERAL DIRECTOR <i>Terry Turner</i> ADDRESS <i>Howell, Missouri</i>			25. DATE RECD. BY LOCAL REG. <i>4-25-57</i>		26. REGISTRAR'S SIGNATURE <i>(MMA) E. Ferry</i>		

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MAY 13 1957

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 *L. Angles Ferry*.....

Licensed Embalmer No. *4960*.....

P. O. Address *Nevada*.....

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.