Health, & Welfare Public Service

6 0 S. 300 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-025185
STATE FILE NUMBER

FILED JUL 21 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 684-A

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY OR TOWN Springfield — Inside Limits Yes [ ] No [X]
c. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hosp. — Length of stay in Ib 1 Day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Laclede
c. CITY OR TOWN Lebanon 0532 0 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS 350 Hoover St. (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: LOUISE Middle: Last: LAWSON

4. DATE OF DEATH Month 7 Day 3 Year 58.

5. SEX Female 1

6. COLOR OR RACE White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH July 3, 1958

9. AGE (In years last birthday) — IF UNDER 1 YEAR: Months, Days 1 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (City and state or country) Laclede County Mo. 0

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME James Lawson

13b. MOTHER'S MAIDEN NAME Nellie Janes

14. NAME OF HUSBAND OR WIFE None.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Address: Mrs. James Lawson, Lebanon, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Premature birth — INTERVAL BETWEEN ONSET AND DEATH 1 d
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 7715
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hemorrhagic disease of newborn.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [✓] 2

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 7-2-58, to 7-3-58 and last saw her alive on 7-2-58
Death occurred at 4:40 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Leslie Burcek MD 0

22b. ADDRESS Springfield Mo

22c. DATE SIGNED 7-8-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 7/4/58

23c. NAME OF CEMETERY OR CREMATORY Rocky Ridge Cemetery

23d. LOCATION (City, town, or county) (State) Laclede County Missouri

24. FUNERAL DIRECTOR None. ADDRESS

25. DATE RECD. BY LOCAL REG. 7-14-58

26. REGISTRAR'S SIGNATURE Effie G. Melton

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 NOT EMBALMED, Student Embalmer No. .....

working under my personal supervision.

Student ..... Signed .....

Signature of Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.