

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-029348

STATE FILE NUMBER

FILED SEP 9 1958 Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 366

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Blue Springs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Independence San & Hosp		Length of stay in lb Days 10	d. STREET ADDRESS 205 So 11th street		Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last John William Lawson			4. DATE OF DEATH Month Day Year Aug 29 1958		
5. SEX Male	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 26 1896	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Clio Iowa		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Lawson			14. MOTHER'S MAIDEN NAME Marietta Carmicheal		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. 495-20-9517	17. INFORMANT Address May Lawson Blue Springs Mo		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver					INTERVAL BETWEEN ONSET AND DEATH 5 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					5810
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.) —		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	—				
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 Aug 15 1958 to Aug 29 58 and last saw him alive on 8-27-58 Death occurred at 2 PM m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) James K. Kiser 140°			22b. ADDRESS Oak Grove Mo		22c. DATE SIGNED 8/30/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug 31 1958	23c. NAME OF CEMETERY OR CREMATORY Blue Springs	23d. LOCATION (City, town, or county) (State) Blue Springs Mo		
24. FUNERAL DIRECTOR ADDRESS Webb Funeral Home Blue Springs Mo		25. DATE RECD. BY LOCAL REG. 8-31-58	26. REGISTRAR'S SIGNATURE James Kiser		

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300 1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

FEB 25 1959  
SEP 12 1958

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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 *William J. ...*.....

Licensed Embalmer No. *473*

P. O. Address *Blue Springs*.....

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.