

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041845

STATE FILE NUMBER

FILED DEC 9 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11311

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Flat River, Mo.</b>
c. FULL NAME OF (IF NOT in hospital, HOSPITAL OR INSTITUTION) <b>24 Hospital St. Louis Children's</b>		Length of stay in lb <b>28 hrs</b>	d. STREET ADDRESS (If outside, give location) <b>3/ 23 Houser Street</b>
3. NAME OF DECEASED (Type or print) First <b>Connie</b> Middle <b>Sue</b> Last <b>Lawson</b>			4. DATE OF DEATH Month <b>11</b> Day <b>23</b> Year <b>58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-23-55</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years last birthday) <b>3</b> IF UNDER 1 YEAR Months <b>6</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
11a. BIRTHPLACE (City and state or country) <b>Farmington, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Lester Franklin Lawson</b>		13b. MOTHER'S MAIDEN NAME <b>Vinnie Graham</b>	14. NAME OF HUSBAND OR WIFE <b>Single</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>None</b>	17. INFORMANT Address <b>Alice Trowbridge, 500 S. Kingshighway</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure &amp; cardiac arrest.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Overwhelming purulent meningitis (prev. H. influenza)</b>			
DUE TO (c) <b>340.0</b>			
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? <b>YES</b> <input checked="" type="checkbox"/> NO <input 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 <b></b> Month, Day, Year a.m. <b></b> p.m. <b></b>			
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 <b>11-22-58</b> to <b>11-23-58</b> and last saw her/him alive on <b>11-23-58</b> Death occurred at <b>11:05 PM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Albert H. Hoppe M.D.</b>		22b. ADDRESS <b>500 S. Kingshighway</b>	22c. DATE SIGNED <b>NOV 24 '58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-24-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	23d. LOCATION (City, town, or county) (State) <b>Bonne Terre, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe 4700 Washington, Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 24 '58</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE (IF POSSIBLE)  
 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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *J W Bumbley* .....

..... Licensed Embalmer No. *3653*

P. O. Address *St Louis Mo*

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.