

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015300

FILED APR 24 1959

Registration District No. _____ Primary Registration District No. _____
STATE FILE NUMBER 2 3401
Register's No. _____

300
1-57
27
91
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. L. Chronic Hosp. 26 Da.		d. STREET ADDRESS (If outside, give location) 3427 Washington	

3. NAME OF DECEASED (Type or print) First Middle Last Marie Lawson			4. DATE OF DEATH Month Day Year 4 4 59		
--	--	--	--	--	--

5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23 1892	9. AGE (In years last birthday) 66	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
-------------	-----------------------	---	----------------------------------	---------------------------------------	---	---------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	-----------------------------------	--	--

13a. FATHER'S NAME Matthew Lawson	13b. MOTHER'S MAIDEN NAME Marie (not given)	14. NAME OF HUSBAND OR WIFE -----
--------------------------------------	---	--------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT Address Lyda Kerone 4646 Dahlia
---	-------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 mo. 2 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Rheumatic Heart Disease - years.		19. WAS AUTOPSY PERFORMED? 1 YES <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 to PART I or PART II of item 18.) 420.0
---	---

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 2-9-59 to 4-4-59 and last saw her alive on 4-4-59 Death occurred at 6:50 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) John W. Beckham, M.D.	22b. ADDRESS 5800 Arsenal	22c. DATE SIGNED 4/4/59
---	------------------------------	----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Apr 7 59	23c. NAME OF CEMETERY OR CREMATORY Calvary	23d. LOCATION (City, town, or county) (State) St. Louis Mo
---	-----------------------	---	---

24. FUNERAL DIRECTOR ADDRESS E.J. Schnur 3125 Lafayette	25. DATE RECD. BY LOCAL REG. APR 6 '59	26. REGISTRAR'S SIGNATURE Earl Smith M.D. R.P.
--	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Thomas R. Fenevick*

Licensed Embalmer No. *3793*

P. O. Address *3125 Lafayette*

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.