

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020987
State File No.

FILED JUL 7 1959

BIRTH NO.

REG. DIST. NO. 128

PRIMARY REG. DIST. NO. 2000

Registrar's No. 719

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO. b. COUNTY TEXAS	
b. CITY (If outside corporate limits, write RURAL and give township) SPRINGFIELD MO.		c. CITY OR TOWN IMPOND MO.	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHNS HOSP.		e. STREET ADDRESS 4429	
3. NAME OF DECEASED a. (First) JOSEPH		b. (Middle) LEE	
c. (Last) LAWRENCE		4. DATE OF DEATH (Month) (Day) (Year) JUNE 28-59	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH AUG. 3/1932
9. AGE (In years last birthday) 26		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days 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 Foreign Country) PIGGOTT, ARK.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME WM O. LAWRENCE	
13b. MOTHER'S MAIDEN NAME MINNIE SMITH		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT'S SIGNATURE OR NAME Bill Lawrence		ADDRESS 7th. Hwy	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hyper pyrexia + Anoxia ANTECEDENT CAUSES DUE TO (b) Sepsis DUE TO (c) Pneumococcal meningitis II. OTHER SIGNIFICANT CONDITIONS Hit by automobile 4 hrs. prior to admission to hosp.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) COUNTY) (STATE) 107			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/25, 1959, to 6/28, 1959, that I last saw the deceased alive on 6/28, 1959, and that death occurred at 3:00 A.M., from the causes and on the date stated above.			
23a. SIGNATURE L. Thomas Mallett		23b. ADDRESS S. 6th Ave. Springfield	
23c. DATE SIGNED 6/28/59			
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE JUNE 30-59	
24c. NAME OF CEMETERY OR CREMATORY MELBORNE		24d. LOCATION (City, town, or county) (State) MELBORNE ARK.	
DATE REC'D BY LOCAL REG. 6-30-59		REGISTRAR'S SIGNATURE Effie S. Meltan	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Rev. Barber 7th. Hwy. No.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUL 2 1959

RECEIVED

JUL 24 1959

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..... *RWT Boob*

Licensed Embalmer No. *384*

P. O. Address. *Int'l. Hrs*

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.