

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021890

FILED JUN 23 1959 Registration District No. 156 Primary Registration District No. 2001 STATE FILE NUMBER Registrar's No. 300

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Newton	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Joplin		c. CITY OR TOWN Seneca	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp.		d. STREET ADDRESS (If outside, give location) 6 mi NW of Seneca	
Length of stay in lb 5 hrs.		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Tommy David Lawson			4. DATE OF DEATH Month Day Year June 11, 1959		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1959	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min. 0 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Joplin, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Francis Lawson		13b. MOTHER'S MAIDEN NAME Peggy Hatfield		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. None		17. INFORMANT Address Mrs. Homer Wilson, rt 2, Seneca, 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) IMMATURITY (25 WEEKS GESTATION)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Premature labor	
	DUE TO (c)	

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 <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 6-11-59 to 6-11-59 and last saw ^{her} _{him} alive on 6-11-59 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE John E. Burch M.D.		22b. ADDRESS Joplin, Mo.		22c. DATE SIGNED 6-12-59	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/11/59		23c. NAME OF CEMETERY OR CREMATORY Seneca Cemetery		23d. LOCATION (City, town, or county) (State) Seneca, Missouri	
24. FUNERAL DIRECTOR W. E. Beddlemore		ADDRESS Seneca Mo		25. DATE RECD. BY LOCAL REG. 6-17-1959		26. REGISTRAR'S SIGNATURE Dove Merriam	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *W E Badlee*

Licensed Embalmer No. *2179*

P. O. Address *Sever*

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.