

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023916
STATE FILE NUMBER

FILED JUN 23 1959

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 106

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Henry</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Brownington</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital # 3</u>		Length of stay in 1b <u>3 1/2 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>Route 2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLEO</u> Middle <u>Franklin</u> Last <u>LAWSON</u>				4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/13/33</u>		9. AGE (In years, <u>25</u> <small>less birthday</small>) IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>laborer</u>		11. BIRTHPLACE (City and state or county) <u>Johnstown, Colo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>H.H. Lawson</u>		13b. MOTHER'S MAIDEN NAME <u>Viola Hollingsworth</u>		14. NAME OF HUSBAND OR WIFE <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>State Hospital Records.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Status Epilepticus</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u> <u>10 hours</u>	
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.) <u>none</u>				
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 <u>11/12/57</u> to <u>6/18/59</u> and last saw ^{her} _{him} alive on <u>6/18/59</u> Death occurred at <u>4:25 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>George Esker M.D.</u> (Degree or title)				22b. ADDRESS <u>State Hospital No 3</u>		22c. DATE SIGNED <u>6/18/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>June-18-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maplewood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Brownington Mo.</u>		
24. FUNERAL DIRECTOR <u>Melvin L. Janssens</u>			ADDRESS <u>Deepwater, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-18-1959</u>		26. REGISTRAR'S SIGNATURE <u>(initial) E. Ferry</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with no traces. All diseases in Part I must be causally related.

OCT 19 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 *Melvin L. Jansen*

Licensed Embalmer No. *4529*

P. O. Address *Appleton, Wis.*

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.