

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031912

FILED VS. SEP 23 1959 / 14

Registration District No. 410

Registrar's No. 25

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY FRANKLIN				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY FRANKLIN											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SULLIVAN		Length of stay in 1 by- 4 YRS		c. CITY OR TOWN SULLIVAN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 104 ORCHARD ST.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 104 ORCHARD ST.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Middle Last AMBRA THOMAS LAWSON				4. DATE OF DEATH Month Day Year SEPT. 17 1959											
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH OCT. 7 1880		9. AGE (last birthday) 78		IF UNDER 1 YEAR Months 11 Days 10		IF UNDER 24 HR Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) VARIOUS				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) CLEBOURNE, TEXAS		12. CITIZEN OF WHAT COUNTRY U. S. A.					
13a. FATHER'S NAME RUBEN LAWSON				13b. MOTHER'S MAIDEN NAME NANCY BARRETT BLOSSOM SQUIRES				14. NAME OF HUSBAND OR WIFE BLOSSOM LAWSON, SULLIVAN, MO.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES 1901-1910				16. SOCIAL SECURITY NO. 498-03-8306A				17. INFORMANT BLOSSOM LAWSON, SULLIVAN, MO.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA										INTERVAL BETWEEN ONSET AND DEATH 3 DAYS					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) BRONCHIAL ASTHMA										YEARS					
DUE TO (c) CARDIAC DECOMPENSATION										YEARS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.m. p.m. Month, Day, Year															
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 1957 to SEP 16 1959 and last saw ^{her} him alive on SEPT 16 59 Death occurred at 1145 A m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE Robert G. ...						(Degree or title)		22b. ADDRESS Sullivan, Mo.				22c. DATE SIGNED Sept 20 59			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE SEPT. 20, 1959		23c. NAME OF CEMETERY OR CREMATORY CAVE SPRING CEMETERY				23d. LOCATION (City, town, or county) (State) SULLIVAN R.R.I. MO.							
24. FUNERAL DIRECTOR Amelton				ADDRESS SULLIVAN, MO				25. DATE RECD. BY LOCAL REG. SEPT. 20 - 59		26. REGISTRAR'S SIGNATURE Thomas G. Humphrey					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 23 1959

FEB 10 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Thomas J. Eaton

Licensed Embalmer No. 5066

P. O. Address Sullivan, 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.