URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-009258

FILED VS MAR 3 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 478

ENDED

1. PLACE OF DEATH
a. COUNTY St.Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights — Length of stay in 1b: 9 days
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St.Mary's Hospital — Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St.Louis
c. CITY OR TOWN Normandy — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 8120 St.Charles Rock Rd. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Dorothy — Middle — Last Lawson

4. DATE OF DEATH: Month February Day 11, Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 5/9/1905
9. AGE (last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Traer, Iowa
12. CITIZEN OF WHAT COUNTRY: U.S.

13a. FATHER'S NAME: Josiah Nesbitt
13b. MOTHER'S MAIDEN NAME: Annabelle Speer
14. NAME OF HUSBAND OR WIFE: Lewis Lawson

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.: Unknown
17. INFORMANT Address: Lewis Lawson, 8120 St.Charles Rock Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart ~~Attack~~ failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Coronary occulusion
DUE TO (c): Myocardial infarction
INTERVAL BETWEEN ONSET AND DEATH

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. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 Aug. '54, to 2-11-60 and last saw her/him alive on 2-11-60
Death occurred at 7:05 am m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] M.D.
22b. ADDRESS: 950 Francis Place, Clayton
22c. DATE SIGNED: 2-12-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2-11-60
23c. NAME OF CEMETERY OR CREMATORY: Local Cemetery
23d. LOCATION (City, town, or county) (State): New Haven, Mo.

24. FUNERAL DIRECTOR — ADDRESS: Albert H.Hoppe, Inc., 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: 2-12-60
26. REGISTRAR'S SIGNATURE: [signature]

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

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_____

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com
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.