

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-009979

FILED VS APR 11 1960 042

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STATE FILE NUMBER

INDEXED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Daviess					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in lb 3 days		c. CITY OR TOWN Gallatin		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) R.R.#1		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Lester Middle Earl Last Lawson				4. DATE OF DEATH Month March Day 31 Year 1960					
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 9-1-53	9. AGE (last birthday) 6 Yrs.	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) None (pupil)			10b. KIND OF BUSINESS OR INDUSTRY Elementary School		11. BIRTHPLACE (City and state or country) Key West Florida		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Orville Lester Lawson			13b. MOTHER'S MAIDEN NAME Evelyn Ann Schubert			14. NAME OF HUSBAND OR WIFE None			
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 Orville L. Lawson			Address Gallatin R.R.#1 Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple septic emboli to brain							INTERVAL BETWEEN ONSET AND DEATH 5 days.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ACUTE mastoiditis							3 weeks		
DUE TO (c) _____									
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 checked="" type="checkbox"/> NO <input 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 3/28/60 to 31 Mar '60 and last saw him alive on 31 Mar '60 Death occurred at 8:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) William A. Lockwood M.D.				22b. ADDRESS 902 Edmond			22c. DATE SIGNED 1 Apr '60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-1-60	23c. NAME OF CEMETERY OR CREMATORY Lock Springs Cemetery		23d. LOCATION (City, town, or county) (State) Daviess County Missouri				
24. FUNERAL DIRECTOR Winkoff-Herman Inc. Address St. Joseph Mo.			25. DATE RECD. BY LOCAL REG. April 1, 1960		26. REGISTRAR'S SIGNATURE Mr. Clark Goodell				

DOCUMENT

Wife, Lockwood, M.D. CERTIFICATION

BY AFFIDAVIT OF

by SAB

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

0081 87

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 Eric Chaney

Licensed Embalmer No. 4679

P. O. Address St. Joseph

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