

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-016509

FILED VS APR 28 1960

Registration District No. 310 Primary Registration District No. 6051 Registrar's No. 83

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>ST. CHARLES</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>ST. CHARLES</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. CHARLES</b>		Length of stay in 1b		c. CITY OR TOWN <b>ST. CHARLES</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>29 TERRIE LANE</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>29 TERRIE LANE, WESTWINDS</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LEE</b> Middle <b>ALLEN</b> Last <b>LAWSON</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>14</b> Year <b>1960</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 4 '58</b>	9. AGE (last birthday) <b>1</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (City and state or country) <b>ST. CHARLES, Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>LIONEL E LAWSON</b>			13b. MOTHER'S MAIDEN NAME <b>BONITA HOUSE BRIDGES</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>LIONEL E. LAWSON, ST. CHARLES, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidental Drowning presumed</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Fell into dump basin with head submerged.</b>				
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 <b>April 14, 1960</b> to <b>April 14, 1960</b> and last saw <b>her</b> him alive on <b>dead when seen</b> Death occurred at <b>pronounced 9:45 a.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Don 2. Randall M.D.</b>				22b. ADDRESS <b>220 S 6th St. Charles, Mo.</b>		22c. DATE SIGNED <b>April 15, 1960</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>APRIL 16, '60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. CHARLES BOROOME</b>		23d. LOCATION (City, town, or county) <b>ST. CHARLES, Mo</b>		23e. STATE <b>(State)</b>		
24. FUNERAL DIRECTOR <b>C.L. PRINSTER, ST. CHARLES, Mo</b>				25. DATE RECD. BY LOCAL REG. <b>APR 15 - 60</b>		26. REGISTRAR'S SIGNATURE <b>Maeella Wilson</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS APR 28 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 Harold O. Kusler

Licensed Embalmer No. 463

P. O. Address Wentzville

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.