

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 17 1960

-60-019977

STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 27

10-6-60
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF physician
 18. I, (b) Subarachnoid hemorrhage

| | | | | | | | | |
|--|---|---|--|--|---|--|---|-------|
| 1. PLACE OF DEATH a. COUNTY Lawrence | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Scott | | | | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Mt. Vernon | | Length of stay in 1b 23 days | | c. CITY OR TOWN Box 88, Route 2 | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| c. FULL NAME OF HOSPITAL OR INSTITUTION Mo. State Sanatorium | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Sikeston | | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Thomas Middle Lawrence Last Lawrence | | | | 4. DATE OF DEATH Month May Day 13 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 11-20-14 | 9. AGE (last birthday) 45 | IF UNDER 1 YEAR Months 0 Days 0 | IF UNDER 24 HR Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Tennessee | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Alfred Thomas Lawrence | | | 13b. MOTHER'S MAIDEN NAME Nancy Smith | | | 14. NAME OF HUSBAND OR WIFE | | |
| 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 Address San. records, Mo. State San., Mt. Vernon, Mo. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) -Probable-Pulmonary-Tuberculosis- | | | | | | | INTERVAL BETWEEN ONSET AND DEATH several months | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Subarachnoid hemorrhage 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 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 10:40 a.m. Month, Day, Year 4-20-60 | | | | | | | | |
| 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 4-20-60 , to 5-13-60 and last saw him alive on 5-13-60 Death occurred at 10:40 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) J. Lewis Tate, M.D. | | | | 22b. ADDRESS Mt. Vernon, Mo. | | 22c. DATE SIGNED 5-13-60 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE May-13-60 | 23c. NAME OF CEMETERY OR CREMATORY Sikeston Cemetery | | 23d. LOCATION (City, town, or county) Sikeston | | 23e. (State) Mo | |
| 24. FUNERAL DIRECTOR Max L. Forrest | | | ADDRESS Mt. Vernon, Mo | | 25. DATE RECD. BY LOCAL REG. 5-12-60 | | 26. REGISTRAR'S SIGNATURE Neil Forrest | |

STATEMENT BY LICENSED EMBALMER

MAY 18 1980

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 Max L. Fousett

Licensed Embalmer No. 4252

P. O. Address W. W. W. W.

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