

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

7637-62-028874
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

FILED AUG 13 1962 **YC-**

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
		ST. LOUIS, MISSOURI		25 DAYS		ILLINOIS		CHRISTIAN		TAYLORVILLE							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
VAH, 915 N. GRAND AVE.						606 EAST POPLAR											
3. NAME OF DECEASED (Type or print) First Middle Last						4. DATE OF DEATH Month Day Year											
MASON L. LAWRENCE						8/3/62											
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 4/19/92		9. AGE (last birthday) 70		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)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY					
MINER								CRYSTAL COUNTY, ILL., U.S.A.									
13a. FATHER'S NAME WILLIAM LAWRENCE				13b. MOTHER'S MAIDEN NAME ALICE 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)				16. SOCIAL SECURITY NO.				17. INFORMANT Address									
YES				WW-I				DELLA LAWRENCE (SISTER) SEE #2									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) <u>Uremia</u>										5 days							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) <u>Renal failure 578X</u>				5 days			
										DUE TO (c) <u>Shock (gastrointestinal bleeding)</u>				5 days			
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 <u>VA 7/9/62</u> to <u>8/3/62</u> and last saw <u>DECK</u> him alive on <u>8/3/62</u> Death occurred at <u>9:40 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.																	
22a. SIGNATURE <i>Benjamin Green</i>				(Degree or title) M.D.		22b. ADDRESS VAH, ST. LOUIS, MO.				22c. DATE SIGNED 8/3/62							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8/5/62		23c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery		23d. LOCATION (City, town, or county) Bulpit, Ill., Illinois.											
24. FUNERAL DIRECTOR Shafer, Funeral Home, Taylorville, Illinois.				ADDRESS		25. DATED BY LOCAL REG. AUG 4 1962		26. REGISTRAR'S SIGNATURE <i>Lois Smith, M.D.</i>									

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis 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.