No. 2
8-43
17-39
X37823

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 17 1945

Registration District No. 71

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 59

State File No. 14329

Registrar's No. 17

**1. PLACE OF DEATH:**

(a) County Putnam

(b) City or town Rural Elm Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: —
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution —
(Specify whether years, months or days)
In this community Life Time

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Putnam

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Livonia
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country —

**3. (a) PRINT FULL NAME** James Clinton Lawson

3. (b) If veteran, name war —

3. (c) Social Security No. 542-28-9837

4. Sex MALE

5. Color or race White

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Martha Lawson

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased February (Month) - 26 (Day) - 1870 (Year)

**8. AGE:** Years 75 | Months 0 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Putnam County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Retired 7 years

MOTHER FATHER

12. Name Adam Yeary Lawson

13. Birthplace Tenn (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name Celestina Jones

15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Raley Munden

(b) Address Unionville Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR - 7 - 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Shipley Cemetery

18. (a) Signature of funeral director Comstock Funeral Home

(b) Address Unionville, Mo. By J. W. Comstock

19. (a) 4-4-45 (Date received local registrar) (b) [signature] (Registrar)

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month MAR day 4

year 1945 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan 26, 1945 to March 4, 1945 that I last saw him alive on March 4, 1945 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death (a) Uremia | |
| Due to | |
| Due to | |
| Other conditions Ch. Cardiac Renal (Include pregnancy within 3 months of death) | |

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature W. H. Goldsmith (M. D. or other) D O

Address Unionville Mo Date signed Mar 7 45

1094

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 4-45-679
Date Filed APR 13 1945

## 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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed James W. Comstock

Licensed Embalmer No. 4197

P. O. Address Unionville, Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

. No. 2B
M—5-43
o I X36930

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

# THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. M 24 1

Registration District No. 291 Primary Registration District No. 5988 Registrar's No.

1. PLACE OF DEATH:
(a) County Putnam
(b) City or town Rural Elm Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James C. Lawson
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased Feb (Month) 26 (Day) 70 (Year)

8. AGE: Years 75 Months 0 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day
year 1945 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Uremia Chronic Nephritis | 1 |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

14329