No. 2
8-43
5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 12 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41892
State File No.

Registration District No. 22-1 Primary Registration District No. 3046 Registrar's No. 30

1. PLACE OF DEATH:
(a) County Moniteau Co.
(b) City or town
(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
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Moniteau 68
(c) City or town Rural 5
(If outside city or town limits, write "RURAL")
(d) Street No. 4 mi North of California 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Frank Lawson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Dollie Lawson
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 5 (Day) 1878 (Year)

8. AGE:

Years	Months	Days	If less than one day
67	11	21	hr. min.

9. Birthplace Moniteau Co (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farmer
11. Industry or business Granville Lawson
FATHER
12. Name
13. Birthplace Moniteau Co (City, town, or county) Mo. (State or foreign country)
MOTHER
14. Maiden name Don't Know
15. Birthplace / (City, town, or county) 9 (State or foreign country)
16. (a) Informant Mrs Frank Lawson
(b) Address California Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-45 (Month) (Day) (Year)
(c) Place: burial or cremation Salem Cem.
18. (a) Signature of funeral director Hugh Williams
(b) Address California Mo.
19. (a) 12-28-45 (Date received local registrar) (b) H. R. Pogsley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 26
year 1945 hour / minute P.M.
21. I hereby certify that I attended the deceased from June 2, 1944, to Dec 26, 1945
that I last saw h. liv. alive on Dec 25, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	1 Week
Due to Generalized Arteriosclerosis	10 years
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 Kenyon Latham (M. D. or other)
Address California, Mo Date signed 12-27-45

1529 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number _____

Date Filed 1-11-46

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 Hugh E Williams

Licensed Embalmer No. 3537

P. O. Address California 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 this body is not embalmed, fact should be so stated above.

No. 2B
3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 226 Primary Registration District No. 3046 Registrar's No. 80

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

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 Frank Larrson
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 M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan 5, 1878 (Month) (Day) (Year)
8. AGE: Years 67 Months 2 Days 1 If less than one day hr. min.
9. Birthplace (City, town, or county) (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) 12-30-45 (Date received by registrar) (H.R. Pofeyoy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day
year 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	
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

SUPPLEMENTARY

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

41892