WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 8827

PLACE OF DEATH

County Jasper

Township Marion

or

Village Carthage

or

City

Registration District No. 408 File No.

Primary Registration District No. 3020 Registered No. 49

(NO. 902 S. Case St.; 5 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Samuel Lawson

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): yes ~~divorced~~

DATE OF BIRTH: Dec (Month) 6 (Day), 1893 (Year)

AGE: 20 yrs. 3 mos. 3 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Cook in Hotel

BIRTHPLACE (City or town, State or foreign country): Carthage Mo

PARENTS

NAME OF FATHER: Joseph Lawson

BIRTHPLACE OF FATHER (City or town, State or foreign country): Greensburg Ind

MAIDEN NAME OF MOTHER: Angeline Cordal

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Cedar Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Cobaugh

(ADDRESS) Carthage Mo #9

Filed Mch 9, 1914. W E Steel REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: March 5th (Month) (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from March 6th, 191__, to Mar 8th, 1914, that I last saw him alive on Mar 8th, 1914, and that death occurred, on the date stated above, at 7-30 m.

The CAUSE OF DEATH* was as follows:

131

132-B Uraemic Poisen

Chronic Nephritis

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) 20

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) L. Orear M. D.

Mch 9, 1914 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Park Cemetery

DATE OF BURIAL: 3/10, 1914

UNDERTAKER: Gierhart

ADDRESS: Carthage Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH INK.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... , 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ...., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS