

FILED JUN 7 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17014

6095 State File No.

 BIRTH NO. 134 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3059 Registrar's No. 191

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR Farmington <u>St. Francois</u> TOWN <u>RURAL</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR Farmington <u>94</u> TOWN <u>1</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: <u>Carpenter Shop-State Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>No. 4 512 Boyce</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>PERCY</u>	b. (Middle) <u>VERNON</u>	c. (Last) <u>LAWS</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>June 1, 1949</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>August 29, 1877</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>9</u>	IF UNDER 1 YEAR Days <u>22</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpentry</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>State Hospital No. 4</u>	11. BIRTHPLACE (State or foreign country) <u>Ste. Genevieve Co., Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Joel J. Laws</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Cunningham</u>	14. NAME OF HUSBAND OR WIFE <u>Kate Belken</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>	16. SOCIAL SECURITY NO. <u>499-03-5576</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Records State Hospital No. 4, Farmington, Mo.</u>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute left ventricular heart failure</u>		<u>15 Min.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) <u>Auricular Fibrillation</u> <u>Abt. 3 yrs.</u>  DUE TO (c) <u>Arteriosclerotic Heart Disease</u> <u>Unknown</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>4200</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from August 24, 1948 to June 1, 1949, that I last saw the deceased alive on June 1, 1949, and that death occurred at 12:15 PM from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>John D. Brems M.D. (1)</u>	23b. ADDRESS <u>State Hospital No. 4, Farmington, Mo.</u>	23c. DATE SIGNED <u>6-3-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June 4, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bonne Terre Catholic Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Bonne Terre, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>June 3, 1949</u>	REGISTRAR'S SIGNATURE <u>Eather Red</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Cozean</u>	ADDRESS <u>Farmington, Missouri</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10.48

AUG 10 1949

RECEIVED

District Health Officer No. 4  
District File Number 649-76  
Date Filed 6-6-49

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 .....  
Student Embalmer

Signed C. H. Cozart.....

Licensed Embalmer No. 4084

P. O. Address Farmington 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.