

34
NORTH CAROLINA STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

175

1 PLACE OF DEATH
 County Forsyth Registration District No. 3X-5837 State _____ Register No. 3
 Township Bethania of Village _____
 City Rural Hall, N.C. St. _____ Ward _____

2 FULL NAME Jasper C. Lawrence
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 (a) Residence. No. Rural Hall, N.C. St. _____ Ward _____
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex male **4 Color or Race** White **5 Single, Married, Widowed, or Divorced (write the word)** married
5a If married, widowed, or divorced Husband of J.C. Lawrence (or) Wife of

6 Date of birth (month, day, and year) Aug. 11th 1848
7 Age years 74 Months 6 Days 8 If LESS than 1 day, hrs. or min.

8 Occupation of deceased
 (a) Trade, Profession, or particular kind of work Merchant
 (b) General nature of industry, business, or establishment in which employed (or employer) Gail Dep't. Store
 (c) Name of employer _____

9 Birthplace (city or town) Forsyth Co.
 (State or country)

10 Name of Father John Lawrence
11 Birthplace of Father (city or town) near Statesville, N.C.
 (State or country)
12 Maiden Name of Mother Lacy Walker
13 Birthplace of Mother (city or town) _____
 (State or country)

14 Informant Mrs. J.C. Lawrence
 (Address) Rural Hall, N.C.

15 Filed 3/5 1923 R. M. Butler
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 Date of Death (month, day, and year) Feb. 19th 1923
17 I HEREBY CERTIFY, That I attended deceased from Aug. 15th 1922 to Feb. 19th 1923
 that I last saw him alive on Feb. 19th 1923
 and that death occurred, on the date stated above, at 6 P. M.
 The CAUSE OF DEATH* was as follows:

Pneumonia & Stomach
Adenoid Tonsils & 2 cm
placation of disease
 (duration) yrs. mos. ds.
 Contributory (SECONDARY) 15 (duration) yrs. mos. ds.

18 Where was disease contracted at home
 if not at place of death?
 Did an operation precede death? no Date of _____
 Was there an autopsy? no
 What test confirmed diagnosis? _____
 (Signed) W. H. ... M.D.
 3/5, 1923 (Address) Rural Hall, N.C.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. (See reverse side for additional space.)

19 Place of Burial, Cremation, or removal Windsor Cemetery **Date of Burial** Feb. 21st 1923

20 Undertaker Wm Cox **Address** Pilot Mt. N.C.

RECORD. Every item of information should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.