**PLACE OF DEATH**

County

Township
or
Village
or
City St Louis (NO. 1414 Residence St. 20 Ward)

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

Registration District No. 791 File No. 25907

Primary Registration District No. 1003 Registered No. 6668

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

**FULL NAME** Henry C. Lewis (Col)

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Male | col | widower |

DATE OF BIRTH _____ (Month) _____ (Day) 1 (Year)

AGE Ab. 63 yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Virginia

PARENTS

NAME OF FATHER Unknown

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) Coroner's Office

(ADDRESS) G. L. Carriere

Filed AUG 3 1910 1910 O. H. Wheeler Bond REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH August 25 (Month) (Day) 1910 (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 3:00 p.m.

The CAUSE OF DEATH* was as follows:

Haemorrhage due to rupture of aortic aneurism

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

Contributory (SECONDARY) Urinary

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

(Signed) G. L. Carriere M. D.

Aug 26 1910 (Address) Deputy Coroner

*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 2625 Baldwin St

PLACE OF BURIAL OR REMOVAL Greenwood

DATE OF BURIAL August 29 1910

UNDERTAKER W. C. Gardner

ADDRESS 2649 Morgan

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

HUGH STEPHENS, JEFFERSON CITY.

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.

**PLACE OF DEATH**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

**BUREAU OF VITAL STATISTICS**
**CERTIFICATE OF DEATH**

County _____

Township _____ or Village _____ or City St. Louis (NO. At Residence St.; 20 Ward)

Registration District No. 791 File No. 25907

Primary Registration District No. 1003 Registered No. 6668

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

**FULL NAME** Church Lewis

SUPPLEMENTARY

**PERSONAL AND STATISTICAL PARTICULARS**

SEX: Male
COLOR OR RACE: Col
SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widower

DATE OF BIRTH _____ (Month) _____ (Day), 1 (Year)

AGE: At 63 yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.

OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country): Virginia

PARENTS
NAME OF FATHER: Unknown
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) X 2944 Easton Ave St Louis Mo
(ADDRESS) Mrs Rosa Becker,

Filed MAR -3 1915, 191__ Max C Starkloff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: August (Month) 25 (Day), 1916 (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 _____

The CAUSE OF DEATH* was as follows:

(Duration) ____ yrs. ____ mos. ____

Contributory (SECONDARY) _____ (Duration) ____ yrs. ____ mos. ____

(Signed) _____ M.

_____, 191__ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____
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 _____

Satisfactory Information Supplied.

Original file, date _____, 19__

All information called for must be written on this Supplementary Certifica

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