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

Do not use this space.

16662

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

City St. Louis (No. 915 Palm St. Ward)

File No.....

Registered No. 4561

2. FULL NAME Richard Lewis

(a) Residence. No. 915 Palm St., 26 Ward.
(Usual place of abode) (If nonresident give city or town and State)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 26th. 1866

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
61	2	19	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Day laborer

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Illinois

PARENTS

10. NAME OF FATHER Frank Lewis

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Illinois

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Illinois

14. INFORMANT Mrs. M. Wilson

(Address) 723 Carroll St.

15. FILED MAY 16 1927 19 Marl C. Starsot REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May, 15th. 19 27

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.... that I last saw h..... alive on ....., 19...., and that death occurred, on the date stated above, at 5.30 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic 93C

Myocarditis (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) None (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 9/8

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) R. S. Ca, M. D

5/16, 1927 (Address) Coroners ~~Office~~

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Eva, Illinois

DATE OF BURIAL May-17- 19 27

20. UNDERTAKER Wacker-Helderle

ADDRESS 2331 S. Bdway

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.