

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

Do not use this space.

35750

**PLACE OF DEATH**

County DeKalb Registration District No. 875  
 Township Washington Primary Registration District No. 6162 File No. \_\_\_\_\_  
 City Washington (No. \_\_\_\_\_) Registered No. 238  
 \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

William H Lewis  
 (a) Residence No. St. Hospital #3 St. 3 Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 2 yrs. 3 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>W.K.</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Mar. 5-1882</u>		
7. AGE	YEARS <u>45</u>	MONTHS <u>8</u>
	DAYS <u>16</u>	If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Farmer</u> (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) <u>Florance Mo</u>		
10. NAME OF FATHER <u>James Henry Lewis</u>		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Laclede Co. Mo</u>		
12. MAIDEN NAME OF MOTHER <u>Elizabeth Moore</u>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Florance Mo</u>		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 22 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1927, to Nov. 22, 1927, that I last saw h. alive on Nov. 22, 1927, and that death occurred, on the date stated above, at 2:30 A m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Epilepsy  
 (duration) 10 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY (SECONDARY) Epilepsy  
 (duration) 10 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH, \_\_\_\_\_ DATE OF \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?  
Clinical  
 (Signed) H. H. Cooper M. D.  
12, 1927 (Address) St. Hospital #3

\*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.

14. INFIRMARY Hospital Records  
St. Hospital #3

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Florance Mo DATE OF BURIAL 11/23 1927

15. FILED 12-19-27 E. R. Thieig REGISTRAR

20. UNDERTAKER Wiggins Funeral Home ADDRESS \_\_\_\_\_

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.

20 1927

