

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.

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**City *St. Louis, Mo.* (No.)

Sanitarium

File No. **21989**Registered No. **6155**

St. Ward)

2. FULL NAME*Kellie J. Lewis*(a) Residence. No. *5873 Highland Ave.* *13* Ward.

(Usual place of abode)

Length of residence in city or town where death occurred *38* yrs. + mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.**PERSONAL AND STATISTICAL PARTICULARS****3. SEX***Female***4. COLOR OR RACE***White***5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)***widowed***5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF****6. DATE OF BIRTH (MONTH, DAY AND YEAR)***June 4. 1879***7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, ... hrs. or min.

*49**4***8. OCCUPATION OF DECEASED**

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

Housework

(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)

*Unknown**Illinois***10. NAME OF FATHER***Unknown***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)

*U.S.A***14.**INFORMANT
(Address)*Wm A. Lacey*
*51300 Arsenal***15.**

FILED

19

Wm A. Lacey
*REGISTRAR***MEDICAL CERTIFICATE OF DEATH****16. DATE OF DEATH (MONTH, DAY AND YEAR)** *6-8* 19 *28***17.**I HEREBY CERTIFY, That I attended deceased from *6-1-27*, 19 *27*, to *6-8* 19 *28*that I last saw her alive on *6-8* 19 *28*, and that death occurred, on the date stated above, at *6:20* A.M.**THE CAUSE OF DEATH* WAS AS FOLLOWS:***myocarditis chronic*
930 a
57A(duration) *2* yrs. mos. ds.**CONTRIBUTORY (SECONDARY)***Arthritis deformans*(duration) *1* yrs. mos. ds.**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Wm A. Lacey* M.D., 19 *28* (Address) *51300 Arsenal*

*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**DATE OF BURIAL***Chuter Ill.**June 8 1928***20. UNDERTAKER****ADDRESS***H. Rindsgoff**5216
Belmar*

