

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

Do not use this space.

13013

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township *St. Louis* Primary Registration District No. **1003**
 City *St. Louis* (No. *Bethesda Hospital 3649 Vista Ave* St. *W* Ward)

File No. **3568**
 Registered No. **3568**

2. FULL NAME *Clarence Ruth Lewis*

(a) Residence. No. *7412 Ethel Ave* St. *4* Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred *3* yrs. *4* mos. *9* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 12 1925*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<i>3</i>	<i>4</i>	<i>9</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *nil* **1206**
 (b) General nature of industry, business, or establishment in which employed (or employer) **197**
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis*
 (STATE OR COUNTRY) *Missouri*

10. NAME OF FATHER *Robert B Lewis*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Missouri*
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Mary M Reid*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Scotland*
 (STATE OR COUNTRY)

14. INFORMANT *Robert B Lewis*
 (Address) *7412 Ethel Ave*

15. FILED *Nov 10 1929*
 REGISTERAR *W. C. Standley*

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mar 21 1929*

17. I HEREBY CERTIFY, That I attended deceased from *March 11 1929* to *March 21 1929* that I last saw her alive on *March 21 1929*, and that death occurred, on the date stated above, at *9:30 A. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Gastric Enteritis

1146 (duration) yrs. mos. *11* ds.

CONTRIBUTORY (SECONDARY) *Acidosis*
non Diabetic (duration) yrs. mos. *4* ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical Symptom*

(Signed) *L. Blouch*, M. D.

, 19 (Address) *1004 W. Pine*

*State the DISEASE CAUSING DEATH, or in deaths from INJURY, the CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

New St. Marcus Cemetery *3-23 1929*

20. UNDERTAKER ADDRESS *4107*

Gregg Hausner and Co *Manchester*
Am

WRITE FAIRLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

