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

Do not use this space. 15003 2107

1. PLACE OF DEATH
County JACKSON Registration District No. 399 File No.
Township KAW Primary Registration District No. 1002 Registered No.
City Kansas City (No. 404 Broadway St. Ward)

2. FULL NAME Robert Lewis
(a) Residence. No. 404 Broadway St., 1 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 M.
4. COLOR OR RACE Col.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unk. 1873
7. AGE Years 56 Months Days If LESS than 1 day, ...hrs. or ....min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work 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) Miss.

PARENTS
10. NAME OF FATHER Will Lewis
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Miss.
12. MAIDEN NAME OF MOTHER Rose Unk
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Miss.

14. INFORMANT Chas. Lewis
(Address) 1445 A. Biddle, St Louis Mo
15. FILED 5/6, 1929 M. M. Crowe asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-29-29
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 ....m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
131
93C (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Chronic Interstitial Nephritis (duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1290
8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? autopsy
4/29/29 (Signed) [signature], M.D.
(Address) Deputy Coroner

*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 Blue Ridge Lawn. DATE OF BURIAL 5/10 1929
20. UNDERTAKER Watkins & Bros ADDRESS 1729 Lydia

...should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ...DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

237
2
2
2