

**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 (No. 1211, South 8th) St. _____ Ward _____

29041
 File No. _____
 Registered No. **8151**
 St. _____ Ward _____

2. FULL NAME

Billie V. Lewis
 (a) Residence. No. 1211 So. 8th St. 12 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 Male 4. COLOR OR RACE White 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) March 11 - 1912

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	8	4	27	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Desloge
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER John Lewis

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

12. MAIDEN NAME OF MOTHER Verna Glaze

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

14. INFORMANT John Lewis
 (Address) 1211 So. 8th St.

15. FILED _____ 19 _____
W. C. Starling REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 7 1929

17. I HEREBY CERTIFY, That I attended deceased from July 1 - 1929 to Aug 7, 1929.
 that I last saw him alive on Aug 6, 1929, and that death occurred, on the date stated above, 3 p. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Endocarditis Rheumatic Acute

CONTRIBUTORY (SECONDARY) 5/10 (duration) yrs. mos. 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? Physical Exam
 (Signed) D. Chorviller M.D.
 8/8, 1929 (Address) 1035 Mission Blvd

*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 _____

Park View Cemetery Farmington 8/9 1929

20. UNDERTAKER Wacker-Hedden ADDRESS 2331 No. Pine

261

