

Mrs Aida Martin
MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

31521

1. PLACE OF DEATH
 County *Camden* Registration District No. *63-1*
 Township *Camden* Primary Registration District No. *9-8-63*
 City *Camden* No. _____ St. _____ Ward _____

2. FULL NAME *Emily Lewis*
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred *1* yrs. *6* 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 *negro*
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*
 5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND or (OR) WIFE OF *Harace Lewis*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *unknown*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. *about 43*
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *House Keeping*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Miss*
 (STATE OR COUNTRY)

PARENTS
 10. NAME OF FATHER *Not known*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *not known*
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER *Not known*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *not known*
 (STATE OR COUNTRY)

14. INFORMANT *Ralph Brummett*
 (Address) *Water, Mo*

15. FILED *Oct 8 29* *Aida Martin*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept. 20* 19*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:
by gunshot wound in chest by persons unknown to jury
(Coroner Jury Verdict)
 _____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY *1st*
 (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.

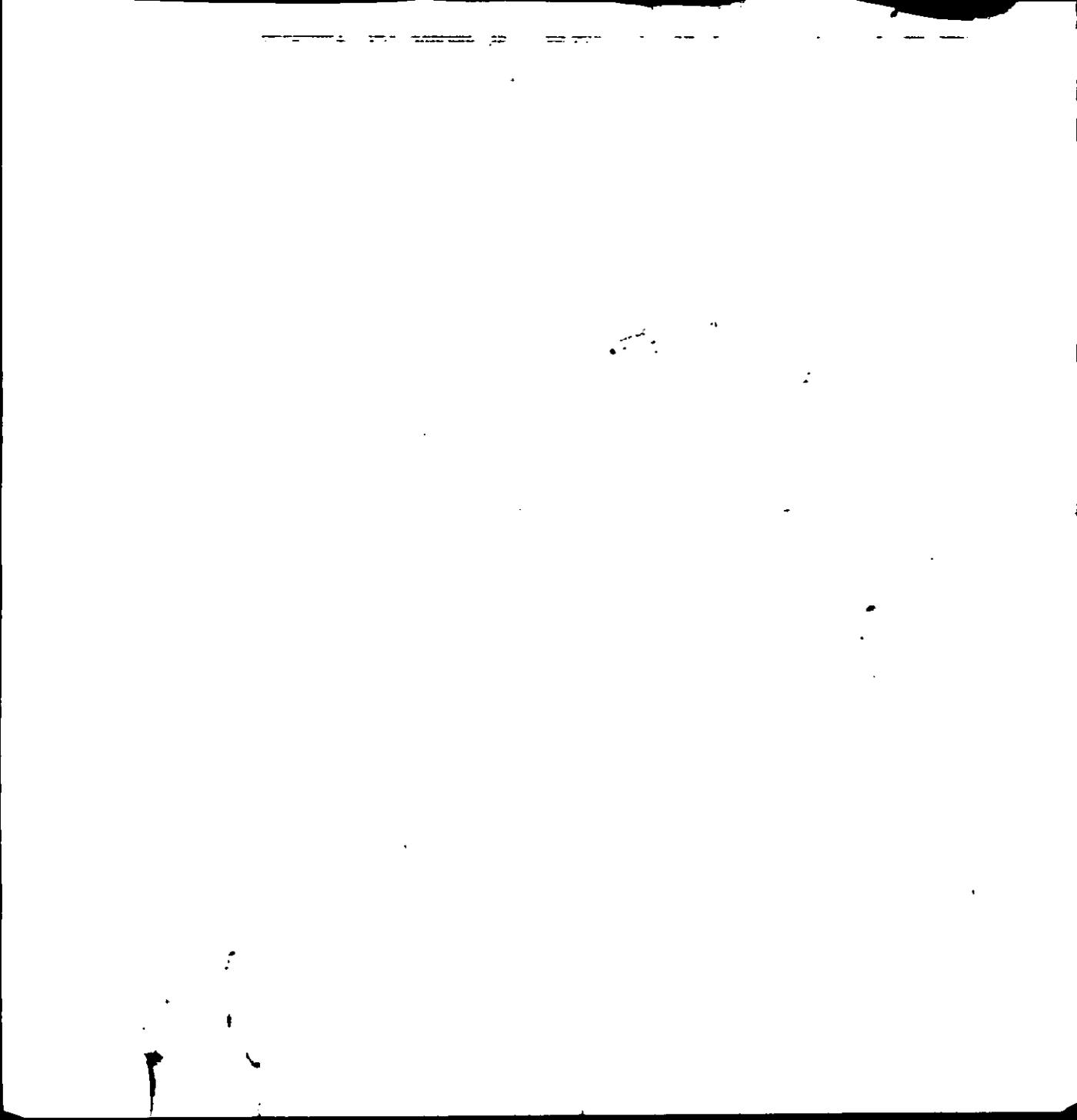
19. DID AN OPERATION PRECEDE DEATH. *no* DATE OF _____
 WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) *James F. Vickroy* (Coroner M. D.)
Sept 20 1929 (Address) *Brookgrove, Mo*

*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
St Mathis Cemetery *9-21 1929*

20. UNDERTAKER ADDRESS
German made Co *Stull mo*



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Pemiscot
Township
City (No.) St. Ward

Registration District No. 651
Primary Registration District No. 3-863

File No.
Registered No. 134

2. FULL NAME

Emily Lewis

(a) Residence. No. St. 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 F 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED Oct 8, 1929 Ada Martin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 20 1929

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 listed above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gun shot wound in Chest - Homicide
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1917
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed), M. D.

, 19 (Address)

*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

19

20. UNDERTAKER ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

S-31521