

APR 23 1930

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

Do not use this space.

7775

1. PLACE OF DEATH

County Buchanan
Township _____
City St. Joseph

Registration District No. 85
Primary Registration District No. 1001
(No. 1523 South 13 Street)

File No. _____
Registered No. 317
St. _____ Ward _____

2. FULL NAME James Wesley Lewis

(a) Residence No. 1523 So. 15 Street 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. 4 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) Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) December 19, 1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
58 2 20

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Steamfitter Retired
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Road House
(STATE OR COUNTRY) Ill.

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown

14. INFANT. Mrs. R. L. Doane
(Address) 1523 So. 13 St--St Joseph Mo

15. FILED John G. [Signature] REGISTRAR
APR 12 1930

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 9 19 30

17. I HEREBY CERTIFY, That I attended deceased from Feb 19, 1930, to March 7, 1930, that I last saw him alive on March 7, 1930, and that death occurred, on the date stated above, at three 3 2 PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

92 A
97
aortic insufficiency
(duration) 2 yrs. 9 mos. _____ ds.

CONTRIBUTORY (SECONDARY) arterial sclerosis
(duration) 1 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 Clinical
(Signed) Charles H. Werner M. D.
Mar. 10, 19 30 (Address) 316 Kirkpatrick Bldg

*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 Memorial Ph Cem DATE OF BURIAL Mar 12 1930

20. UNDERTAKER H. W. Schaefer ADDRESS 3802 Union St

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.

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