

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

Do not use this space.

640

*Case*  
PLACE OF DEATH  
County *Case* Registration District No. *213*  
Township *Jefferson* Primary Registration District No. *9014*  
City *Jefferson* (No. ....) St. .... Ward .....

File No. *22*  
Registered No. ....  
St. .... Ward .....

2. FULL NAME *Lena M. Ewen*  
(a) Residence No. *426 Case* 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* mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *W R M. Ewen*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 15 - 1884*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*46 8 5*

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

9. BIRTHPLACE (CITY OR TOWN) *Ontario*  
(STATE OR COUNTRY) *Canada*

10. NAME OF FATHER *R R Casey*

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

12. MAIDEN NAME OF MOTHER *Henrietta Cusack*

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

14. INFORMANT *W R M. Ewen*  
(Address) *426 Case Ave*

15. FILED *2-6-31* *W Bedford* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 21 1931*

17. I HEREBY CERTIFY, That I attended deceased from *January 16 1931* to *January 20 1931*  
that I last saw him alive on *January 20 1931*, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Pneumonia*

*108*  
*121* (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) *Chronic nephritis*  
(duration) *10* yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
 NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no* DATE OF *Ⓟ*

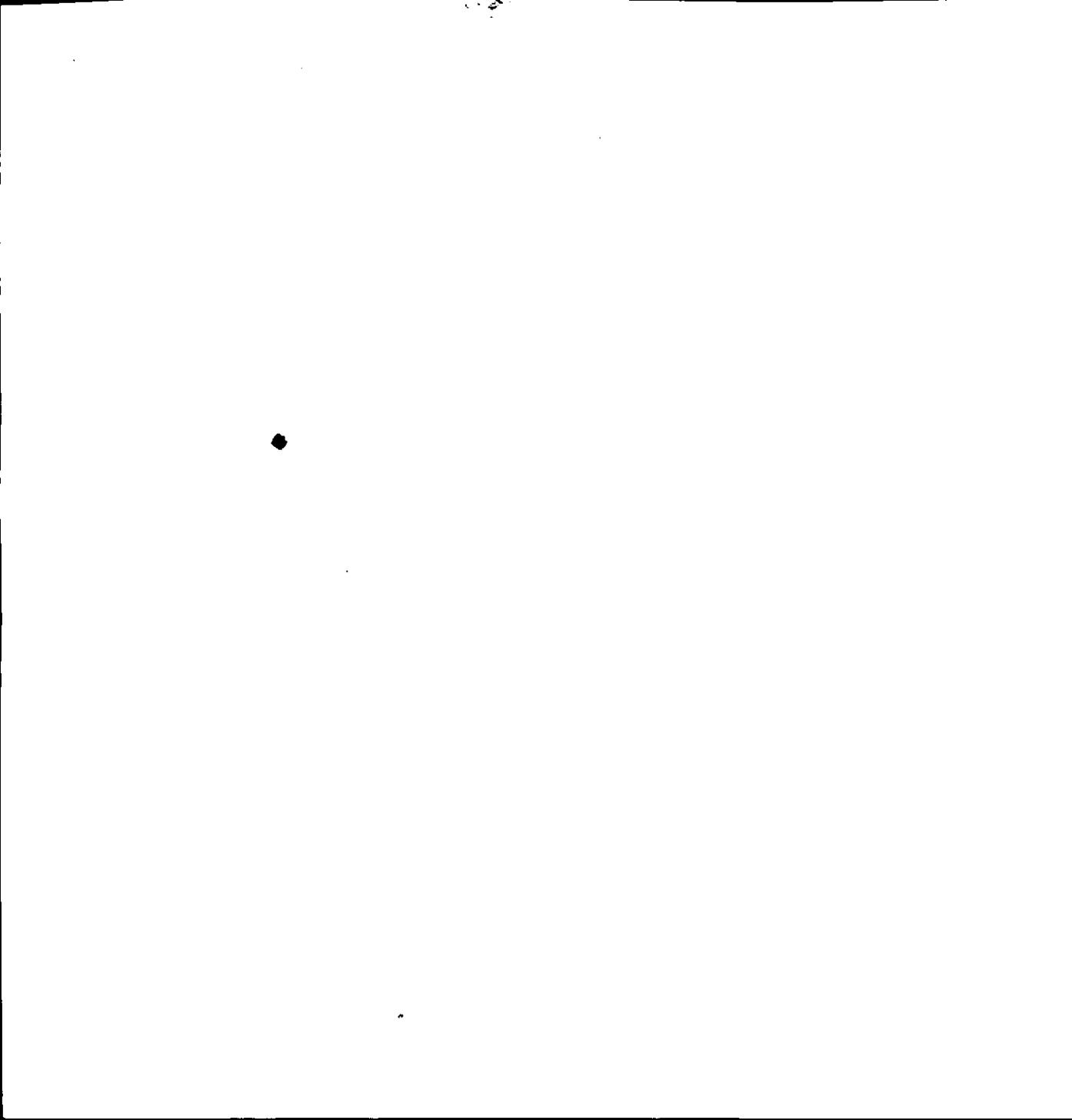
WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Physical signs*  
(Signed) *[Signature]*, M. D.  
, 19 *(Address) 1111 1/2 Bldg, Jefferson City 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 *Provision Cem* DATE OF BURIAL *Jan 22 1931*

20. UNDERTAKER *James James* ADDRESS *J C 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 Cole

Registration District No. 213

File No. 22

Township

Primary Registration District No. 3014

Registered No.

City Jays City (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward)

**2. FULL NAME**

Lena McEwen

(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 W 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.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 2-6- 1931 W. Bedford Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 21 1931

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Pneumonia  
Lobar  
108  
Other contributory causes of importance:  
Chronic nephritis

Date of onset

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Doctor Jose, M. D.

(Address) \_\_\_\_\_

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

079-5