

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

Do not use this space.

25406

1. PLACE OF DEATH

106 County Janey Registration District No. 861 File No. _____
 Township Dwan Primary Registration District No. 6132 Registered No. 17
 City Jacobsburg (No. _____) St. _____ Ward _____

2. FULL NAME

Lewis Mevin Corliss

(a) Residence No. _____ St. _____ Word _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. 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 Widowed
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 21, 1855

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	77	6	29	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Salem
 (STATE OR COUNTRY) New Hampshire

PARENTS

10. NAME OF FATHER Richard Corliss

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Ray Dennison
 (Address) Chalwick, Mo

15. FILED 7-21-33 Irene Brown
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 20 1933

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 _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

CONTRIBUTORY (SECONDARY)

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) J. H. Gilbert, 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 Love Star Cemetery DATE OF BURIAL July 21 1933
 20. UNDERTAKER None ADDRESS None

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.

MS 26 1933

