REC'D FEB 15 1939

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

2128
Do not use this space.

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.

1. PLACE OF DEATH
(a) County DAVIESS — Registration District No. 255
(b) Township — Primary Registration District No. 4155 — Registered No.
(c) City WINSTON — (d) Street No. — St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME WILLIAM LEWIS
(a) Residence, No. HAMILTON St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): WIDOWED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) NOV 28 1864

7. AGE: YEARS 74 — MONTHS 1 — DAYS 29 — If LESS than 1 day, ...hrs. or ....min.

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

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

FATHER
13. NAME JOHN LEWIS
14. BIRTHPLACE (CITY OR TOWN) KENTUCKY (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME MARGARET WISKERSON
16. BIRTHPLACE (CITY OR TOWN) ST JOSEPH (STATE OR COUNTRY) MO

17. INFORMANT MRS ISAACS EDWARDS (ADDRESS) WINSTON MO

18. BURIAL, CREMATION, ~~OR REMOVAL~~ PLACE HAMILTON DATE JAN 29 1939

19. FUNERAL DIRECTOR KATE STROUP (ADDRESS) WINSTON MO

20. FILED Jan 28 1939 F. R. Wilson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/27 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 1 1939, to Jan 27 1939
I last saw h. ~~was~~ alive on Jan 27 1939. Death is said to have occurred on the date stated above, at 8:25 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
cerebral hemorrhage	1/27/39
Sgd	

Other contributory causes of importance:
chronic cystitis:
typer prostate

Name of operation ..... Date of ..... No
What test confirmed diagnosis? clinical 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) Fred R. Wilson M. D.
(Address) Winston Mo

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, Virgil V. Strang, Licensed Embalmer No. 4074

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Virgil V. Strang

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed Virgil V. Strang

Licensed Embalmer No. 4074

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)