

REC'D FEB 28 1939

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

4098  
 Do not use this space.

## 1. PLACE OF DEATH

(a) County Stoddard Registration District No. 834  
 (b) Township New Lisbon Primary Registration District No. 6103 Registered No. 3  
 (c) City New Lebanon, Mo. (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

Jessie Royal Lewis  
 (a) Residence, No. Marion, Mo. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 15, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1939, to Jan. 15, 1939  
 I last saw him alive on Jan. 15, 1939 Death is said to have occurred on the date stated above, at 11:30 a.m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 28, 1938

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

7. AGE YEARS MONTHS DAYS 1 17 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

Pneumonia  
 Date of onset \_\_\_\_\_

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

Other contributory causes of importance:  
7 month baby had yellow jaundice at 1 month of age.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Leban, Mo.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No.

13. NAME Wilson Lewis

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Brownwood, Mo.

15. MAIDEN NAME Katie Rhodes

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sturdivant, Mo.

17. INFORMANT (ADDRESS) Wilson Lewis  
Advance, Mo. R-1

18. BURIAL, CREMATION, OR REMOVAL PLACE Sturdivant, Mo. Jan 16, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ray & Margo  
Advance, Mo.

20. FILED 2/6 1939 B. S. McFee Local Registrar.

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? 3  
 If so, specify \_\_\_\_\_  
 (Signed) E. D. Masters M. D.  
 (Address) Advance, Mo.

109

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, \_\_\_\_\_

\_\_\_\_\_, or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

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Do not use this space.

1. PLACE OF DEATH  
(a) County Stoddard Registration District No. 834  
(b) Township New Lebanon Primary Registration District No. 6103 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (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 Jimmie Royal Lewis  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) mf

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-15-1939

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

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
1 17

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

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.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

Pneumonia, bronchial  
Date of onset 10-1-38

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

Other contributory causes of importance:  
7 months baby had yellow jaundice at 1 month of age cold and exposure

FATHER  
13. NAME

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

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

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

MOTHER  
15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:

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

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

17. INFORMANT (ADDRESS)

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

Specify whether injury occurred in industry, in home, or in public place.

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

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

19. FUNERAL DIRECTOR (ADDRESS)

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

20. FILED \_\_\_\_\_, 19\_\_\_\_

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

If so, specify \_\_\_\_\_ (Signed) J. C. Mantus, M. D.

(Address) Advance

Local Registrar.

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

