

0367 MAR 9 1939

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

5580
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 299
 (b) Township Maun Primary Registration District No. 1002
 (c) City Kennas (d) Street No. 3235 Thomson Registered No. 779
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (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 Ecl Lewis

(a) Residence, No. 3235 Thomson 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

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED unknown
 (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 21 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 0 28

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. Lumber
 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) Kansas City mo

FATHER 13. NAME Mitchel Lewis

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

MOTHER 15. MAIDEN NAME Josephine Lynch

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

17. INFORMANT Mrs Thomas Lewis
 (ADDRESS) 422 W 11th St

18. BURIAL, CREMATION, OR REMOVAL PLACE mt St Mary DATE Feb. 23-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Paranther Bros.

20. FILED 722 1939 M. M. Browne
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-19-39 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____

I last saw Deputy Coroner live on _____, 19____. Death is said to have occurred on the date stated above, at _____, Mo.
 The principal cause of death and related causes of importance were as follows:

Chronic aortic aneurysm of arch of aorta Rupture of the aorta
 Date of onset 4/6
 Other contributory causes of importance: Atherosclerosis

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes

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) W. H. ... M. D.
 _____ (Address) Gen Hosp; K. C. Mo

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.

STATEMENT TO BE MADE BY THE EMBALMER
OF THE BODY OF THE DECEASED
WHICH IS TO BE EMBALMED

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.