

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

11304
 Do not use this space.

REC'D APR 19 1939

1. PLACE OF DEATH

(a) County LACLEDE Registration District No. 453 233-5000
 (b) Township CASCONADE Primary Registration District No. 3-6-17
 (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 JOHN CLARK 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

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF NORA ANDERSON
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAR. 9, 1872
 7. AGE YEARS 77 MONTHS 0 DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MAR 18 1939
 22. I HEREBY CERTIFY, That I attended deceased from 3-17, 1939 to 3-18, 1939
 I last saw him alive on 3-17, 1939 Death is said to have occurred on the date stated above, at 2:15 A.M.
 The principal cause of death and related causes of importance were as follows:

Bronchial Pneumonia

Date of onset

Other contributory causes of importance: 1914

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) J. W. Lindsey, M. D.

12. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) MILLER Co. Mo. 0

FATHER 13. NAME COLE LEWIS

14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo. 9

MOTHER 15. MAIDEN NAME Est. Brown

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

17. INFORMANT Chas Lewis (ADDRESS) Compton's Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Inter Chapel DATE MAR 1939

19. FUNERAL DIRECTOR (NAME) PALMER'S (ADDRESS) LEBANON, Mo.

20. FILED Mar. 21, 1939 Mrs. Vida Lambeth Local Registrar.

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. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF HEALTH OFFICERS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by

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

Signed.....

[Handwritten Signature]

Licensed Embalmer No. *1161*

P. O. Address *Lebanon Mo*

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.

Y if any of the following

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

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Do not use this space.

PLACE OF DEATH

(a) County Wade Registration District No. 453
(b) Township Gasconade Primary Registration District No. 3619
(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

Clark 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

3. SEX m 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 Nora Anderson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-9-1862
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 77 0 7
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer
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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 18 1939

22. I HEREBY CERTIFY, That I attended deceased from 3-17 to 3-18, 1939
I last saw him alive on 3-17, 1939. Death is said to have occurred on the date stated above, at 3-17 m.
The principal cause of death and related causes of importance were as follows:

Bronchial
Pneumonia

Date of onset

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miller Co Mo

FATHER 13. NAME Cole Lewis

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

MOTHER 15. MAIDEN NAME not known

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

17. INFORMANT (ADDRESS) Clark Lewis

18. BURIAL, CREMATION, OR REMOVAL PLACE Porter Chapel DATE 3-18-39

19. FUNERAL DIRECTOR (ADDRESS) Palmer

20. FILED 5-13 1939 Walter Hicker Local Registrar

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) J. H. Lindsay, M. D.

(Address) Conway 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.

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

MISSOURI STATE BOARD OF HEALTH

MAY 12 1955