

AUG 7 1939

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

27128
Do not use this space.

1. PLACE OF DEATH

(a) County Vernon Registration District No. 875
(b) Township Wabank Primary Registration District No. 6162 Registered No. 188
(c) City Wesley (d) Street No. SF High # 3 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 Dr. Joseph F. Lewis

(a) Residence, No. Webb City 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 Elizabeth Lewis

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 1 - 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 9 26

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. mine operator
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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio13. NAME Geo. Lewis14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio15. MAIDEN NAME Eliza Fleming16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?17. INFORMANT Hay record
(ADDRESS)18. BURIAL, CREMATION, OR REMOVAL
PLACE Webb City Cem. DATE 7/29/3919. FUNERAL DIRECTOR (NAME) (ADDRESS) Hedger Nelson
Webb City Mo.20. FILED July 27 1939 Allen V. Hays
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 27 193922. I HEREBY CERTIFY, That I attended deceased from July 28 1939, to July 27 1939

I last saw him alive on July 27 1939. Death is said to have occurred on the date stated above, at 7:40 P.M.

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

Pneumonia (Hypostatic)?
Date of onset 7-23-39

Other contributory causes of importance:
Fracture of right femur (accidental fall)

Name of operation None 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. C. Long, M. D.
(Address) State Hospital #5
Webb City Mo

186
97

RECEIVED
District Health Officer No. 7,
District File Number 7-39-113
Date Filed 8-4-39

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.....

C W Hedge

....., Registered Apprentice No.

working under my personal supervision

Signed *C W Hedge*

Licensed Embalmer No. 2859

P. O. Address Webb City, 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

27128
Do not use this space.

1. PLACE OF DEATH

(a) County Vermont Registration District No. 875-
(b) Township Washington Primary Registration District No. 6162
(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.

Registered No. 188

2. PRINT FULL NAME

Joseph F Lewis
(a) Residence, No. _____ 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

MEDICAL CERTIFICATE OF DEATH

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 _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-27 1939

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

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____, 19____
I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
77 9 26

Broncho Pneumonia Date of onset 10/7/38

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 _____

Other contributory causes of importance:
fracture of rt femur
M. M. D.

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

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

FATHER
13. NAME _____

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

MOTHER
15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19____

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. C. Long, M. D.
(Address) State Hosp # 3
Newark

Local Registrar

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.
REGISTRARS SHOULD BE PLACED IN PLAIN TERMS. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

1939
S-27128