

Registration District No. 791 Primary Registration District No. 1344

Registrar's No. 11140

1. PLACE OF DEATH:

(a) County St Louis
 (b) City or town St Louis
 (c) Name of hospital or institution: Homer G Phillips
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 mos 16 days
 In this community Unknown
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Arthur Lewis
 3. (b) If veteran, name war unk
 3. (c) Social Security No. unk

4. Sex male 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Sep
 6. (b) Name of husband or wife unk
 6. (c) Age of husband or wife if alive unk years
 7. Birth date of deceased Aug 17
 (Month) (Day) (Year)

8. AGE: Years 50 Months 3 Days 28
 If less than one day hr. min.

9. Birthplace unk Louisiana
 (City, town, or county) (State or foreign country)

10. Usual occupation unk

11. Industry or business unk

12. Name William Lewis

13. Birthplace Kentucky
 (City, town, or county) (State or foreign country)

14. Maiden name unk
 15. Birthplace unk
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Florence G Spotts

(b) Address Homer Phillips Hospital

17. (a) (Burial, cremation, or removal) Washington
 (b) Date thereof 12-12-39
 (Month) (Day) (Year)

18. (a) Signature of funeral director W. Whittey

(b) Address 3500 Robt

19. (a) DEC 28 1939 (Date received local registrar)
 (b) J. P. Radlock (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
 (c) City or town St Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2935 Laclede
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 5
 year 1939 hour 5:00 minute 55 P. M.

21. I hereby certify that I attended the deceased from May 19, 1939, to Dec 5, 1939;
 that I last saw him alive on Dec 5, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Bladder with Local Metastasis
 Duration 18 mos

Due to Urinary bladder
 Due to _____

Other conditions 51
 (Include pregnancy within 3 months of death)

Major findings: 51
 Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) _____ (e) Means of injury 1

23. Signature H. C. Lewis (M. D. or other)
 Address 2601 N Whittier Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

42017
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791
(b) Township..... Primary Registration District No. 1003
(c) City St Louis (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. 11140

2. PRINT FULL NAME

Arthur 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 Mar
(write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 5, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 17 1889

19..... to....., 19.....

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
30 3 78

I last saw h..... 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:

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

Date of onset

Other contributory causes of importance:

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

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 2-16-40, 19..... J B Biedack 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) H.C. Living, M. D.

(Address) 2601 N. Whittier

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SUPPLEMENTARY

