

1940 JUN 17 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **17709**
Registrar's No. **2236**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution: **General Hosp #2 22nd & Mcay**
(d) Length of stay: In hospital or institution **4 Weeks.**
In this community **4 Weeks.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(d) Street No. **1910 E. 19th St.**
(e) If foreign born, how long in U. S. A.?

8. (a) PRINT FULL NAME **DeLoris Hannah Lewis**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Fe** 5. Color or race **Col** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **April 9 1940** (Month) (Day) (Year)

8. AGE: Years **1** Months **23** Days **4** If less than one day hr. min.

9. Birthplace **Kansas City Mo** (City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business _____

12. Name **Willie Lewis**

13. Birthplace **Kansas City Mo** (City, town, or county) (State or foreign country)

14. Maiden name **Hannah Mae Lewis**

15. Birthplace **Little Rock Ark.** (City, town, or county) (State or foreign country)

16. (a) Informant **Hannah Mae Lewis**

(b) Address **1910 E. 19th St**

17. (a) **Burial** (b) Date thereof **5-31-1940** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Blue Ridge Dawn**

18. (a) Signature of funeral director **Livingston Brady**

(b) Address **1513 Tsoyax**

19. (a) **May 31, 1940** (b) **M. H. Brown** (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** day **22** year **40** hour _____ minute _____ M.

21. I hereby certify that **Carroll** the deceased from **5:40 P.** 19 **40** at _____ death occurred on the date and hour stated above.

Immediate cause of death **Dehydration**

Due to _____

Due to _____

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

Major findings: 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? **361** While at work? _____ (Specify type of injury) **5**

23. Signature **Carroll** (Physician's name) Address **1910 E. 19th St** Date signed _____

Duration _____
Physician _____
Underline the cause to which death should be charged statistically.

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

20 PR

John A. ...
John A. ...

2180151

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 *[Signature]*
Licensed Embalmer No. 3388
P. O. Address K. C. M.

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.

Registration District No. 399

Primary Registration District No. 1082

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town R.C.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 -
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 In this community..... (Specify whether
 years, months or days)

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

4. Sex 7 5. Color or race col 6. (a) Single, widowed, married, divorced S.
 6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 13 h. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

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

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

16. (a) Informant..... (b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 5/31/40 (b) M. M. Browne (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State..... (b) County.....
 (c) City or town..... (If outside city or town limits write "RURAL")
 (d) Street No..... (If rural, give location)
 (e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 2 day 22 year 1940 hour..... minute..... M.

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

Immediate cause of death Dehydration
Malnutrition N.M.D.

Due to.....
 Due to.....

Other conditions (Include pregnancy within 3 months of death) 108

Major findings: Of operations.....

Of autopsy Inspection

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) Means of injury.....

23. Signature W. H. Baker (M. D. or other) K. P. Mo
 Address..... Date signed.....

SUPPLEMENTAL

MOTHER FATHER

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 2236

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
.....
(If not in hospital or institution, write street number or location) .
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(If outside city or town limits write "RURAL")
(d) Street No. 1910 1619
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME Delores H Lewis

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex ♀ 5. Color or race cd 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased..... (Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

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

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

16. (a) Informant..... (b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22 year 1940 hour..... minute..... M.

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

Immediate cause of death.....

Dehydration

Due to.....

Due to.....

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

Major findings: 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) (c) Means of injury.....

23. Signature..... (M. D. or other)..... Address..... Date signed.....

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL COPY

$$\begin{array}{r} 1528 \\ \underline{152} \\ \hline \end{array}$$

$$\begin{array}{r} 800 \\ \underline{07} \\ \hline 56100 \end{array}$$

$$\frac{3}{11} = 9$$

$$\frac{1}{7} = 3$$

$$\frac{7}{7} = 21$$

$$24 - 21 = 3$$

$$12 \times 3 = 24$$

24 for program

12 program died

$\frac{3}{11}$ of real cost of 9.

$\lambda = \text{no of program}$

$$12 : \frac{24}{9} = 9 \frac{3}{11} \frac{3}{11}$$

$$216 \times 1$$

60441-S