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X2149

JUN 22 1940

State File No. _____

Registration District No. _____

Primary Registration District No. 3001

Registrar's No. 151

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirksville, Mo

(c) Name of hospital or institution: Community Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Apr. 30/40 to date.
(Specify whether years, months or days) 10 years

3. (a) PRINT FULL NAME Miles Abram Lewis 200

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Grace E. Lewis

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

7. Birth date of deceased 11 27 1875
(Month) (Day) (Year)

8. AGE: Years 64 Months 6 Days 20 If less than one day hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Everett Milton Lewis

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

14. Maiden name Grace Flatt

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

16. (a) Informant Joy Lewis Hayes

(b) Address Toledo, Iowa

17. (a) Cremation (b) Date thereof 6/13/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place, burial or cremation Valhalla Crematory, St. Louis, Mo.

18. (c) Signature of funeral director Burial: Rose Hill Cemetery, Kirksville, Iowa

(b) Address Kirksville, Mo.

19. (a) June 18/40 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

(c) City or town Kirksville, Missouri
(If outside city or town limits, write "RURAL")

(d) Street No. 600 N. Boundary St.
(If rural, give location) X

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17
year 1940 hour 8 minute 55 a.m.

21. I hereby certify that I attended the deceased from Apr. 30 1940
1940 to June 17 1940

that I last saw him alive on June 17 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of bowels, liver & pancreas!

Due to _____

Due to _____

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

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy Same

Underline the cause to which death should be charged statistically.

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? _____

3 While at work? _____ (Specify type of place)
(d) Means of injury _____

23. Signature [Signature] (Date or other) 3 00

Address Kirksville Mo Date signed 6/18/40

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

46

RECEIVED

District Health Officer No. 10

District File Number 6-40-1308

Date Filed June 19, 1940

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.....

Dee Riley

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Dee Riley

Licensed Embalmer No. 3908

P. O. Address Kirksville, 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.

b. 23
21-40
X22639

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 17728

Registration District No. 4

Primary Registration District No. 3001

Registrar's No. _____

1. PLACE OF DEATH

(a) County Adair
(b) City or town Parisville Mo.
(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)

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.

3. (a) PRINT FULL NAME

Miles Abram Lewis

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

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

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 64 Months 6 Days 20 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 _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Spencer L. Freeman (Registrar's signature)

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 6 day 17 year 1945 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:

Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 _____

23. Signature H. H. Casper (M. D. or other) _____

Address Parisville Mo Date signed _____

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

SUPPLEMENTARY

No. 2B
2-21-40
X-28

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 17728

Registration District No. 4

Primary Registration District No. 3001

Registrar's No. 151

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Fayetteville
(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)

3. (a) Wiles Abram Lewis

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

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

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

64 6 20 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

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)

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

20. DATE OF DEATH: Month June day 17 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 Carcinoma of the esophagus, liver and pancreas

Due to probably primary in liver or perhaps metastatic

Due to with metastases to pancreas & bowel

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

Major findings: Of operations _____

Of autopsy 46

Physician James

Underline the cause to which death should be charged statistically.

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? _____

Without work? (Specify type of place) (e) Means of injury _____

23. Signature M. H. Casner (M. D. or other) DO

Address Fayetteville Date June

SUPPLEMENTARY