

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27688  
3322  
Registrar's No.

Registration District No. 399

Primary Registration District No. 11002

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Home 2625 Lawn 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 25 Years  
years, months or days)

3. (a) PRINT FULL NAME George M. Lewis 201  
3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Minnie H. Lewis  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased March 15 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
74 5 6 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Merchant

11. Industry or business Same

MOTHER FATHER { 12. Name John A. Lewis  
13. Birthplace Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Josephine Krustings  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Gladys McLaurine  
(b) Address 609-a East 31st.  
17. (a) Burial (b) Date thereof Aug 23 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Rose & Henderson  
(b) Address 4139 E. 15th St. K.C. Mo.

19. (a) Aug. 22, 1940 (b) M. M. Criss  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL.")  
(d) Street No. 2625 Lawn St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21  
year 1940 hour 3 A.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from once  
August 20, 1940 to \_\_\_\_\_, 1940;  
that I last saw him alive on Aug. 20, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage followed by fall causing skull fracture  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Major findings: Of operations 1862  
Of autopsy 0 U + 1

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 Aug 20, 1940  
(c) Where did injury occur? Kansas City, Jackson, Missouri  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industry, place, in public place?  
In front of home. Fell in street.  
While at work \_\_\_\_\_ (Specify type of place)  
(e) Means of injury Cerebral Hemorrhage followed by fall in street causing skull fracture  
23. Signature Dr. Wallace H. Graham (M. D. or other) M.D.  
Address 5-18 Angyle Bldg. K.C., Mo. Date signed 8-22-40

**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 \_\_\_\_\_

*John P. Camp*  
2215-5

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

*R.C. 710*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**