

S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 19 1940
318

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28551
State File No.
Registrar's No. 711

Registration District No. Primary Registration District No. 2001

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution: St Johns Hospital
(d) Length of stay: In hospital or institution _____

In this community _____
years, months or days
3. (a) PRINT FULL NAME Catherine C Lewis

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: October 22, 1911
(Month) (Day) (Year)

8. AGE: Years 28 Months 10 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace: Unknown of Alabama
(City, town, or county) (State or foreign country)

10. Usual occupation: school teacher

11. Industry or business: in school

12. Name: Robert B Lewis
13. Birthplace: Unknown Missouri
(City, town, or county) (State or foreign country)

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

16. (a) Informant: Robert B Lewis
(b) Address: 663 Cherry, City

17. (a) Burial (b) Date thereof: 8-30-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Maple Park

18. (a) Signature of funeral director: Alvin Schaeffer
(b) Address: Springfield Mo

19. (a) Aug 30, 1940 (b) W. E. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield
(d) Street No. 663 Cherry
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 28
year 1940 hour 9:30 minute A M.

21. I hereby certify that I attended the deceased from 8/6/40 19 to 8/28/40 19;
that I last saw her alive on 8/28/40 19;
and that death occurred on the date and hour stated above.

Immediate cause of death: Brain abscess
Duration: 1 mo.

Due to: (No primary focus found at autopsy)

Due to: AN
Other conditions: --
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: no op.
Of operations: no op.
Of autopsy: Brain abscess, nothing else.
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? Y

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
Signature: J. B. Lemmon (M. D. or other) IMA
Address: Springfield, Mo. Date signed: 8/29/40

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

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 Lewis D. Sharpe

Licensed Embalmer No. 3802

P. O. Address Springfield 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.

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