

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.

OCT 12 1940  
Registration District No. 21

Primary Registration District No. 3009

1. PLACE OF DEATH:  
(a) County CAPE  
(b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Francis  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days (Specify whether  
In this community 27 yrs.  
years, months or days)

3. (a) PRINT FULL NAME Lilye Lewis  
3. (b) If veteran, name war —  
3. (c) Social Security No. NONE

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M.  
6. (b) Name of husband or wife Chas. Lewis 6. (c) Age of husband or wife 72 years  
7. Birth date of deceased July 18 1876  
(Month) (Day) (Year)

8. AGE: Years 64 Months 1 Days 24 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business —

MOTHER FATHER  
12. Name Joe Ganser  
13. Birthplace Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Antwan  
15. Birthplace ?  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Chas. Reeves  
(b) Address Farranburg, Mo.  
17. (a) Burial (b) Date thereof Sept 13  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Farranburg, Mo.  
18. (a) Signature of funeral director Adrian Ellis  
(b) Address St. Louis, Mo.  
19. (a) 9-17-40 (b) J. M. Thompson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County New Madrid  
(c) City or town Farranburg, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12  
year 1940 hour 4 minute 2 M.  
21. I hereby certify that I attended the deceased from Sept. 9  
1940, to Sept 12 1940  
that I last saw her alive on Sept 11 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy  
Due to \_\_\_\_\_  
Duration \_\_\_\_\_

Due to Diabetes  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 54  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? 11  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature R. T. Smith (M. D. or other) MD  
Address Cape Girardeau, Mo. Date signed 9/14/40

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**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.**