

FEB 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3174

State File No. _____

Registration District No. 467

Primary Registration District No. 4280

Registrar's No. 7

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

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Aurora
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
17 East Church St
(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) PRINT FULL NAME William M Lewis

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

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

6. (b) Name of husband or wife Ina Lewis 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased March 1 1882
(Month) (Day) (Year)

8. AGE: Years 53 Months 3 Days 11 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business Retired

12. Name A Lewis

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

14. Maiden name Mattox

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

16. (a) Informant Mrs Ina Lewis

(b) Address Aurora Mo.

17. (a) Burial (b) Date thereof 1/30/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Aurora Mo.

18. (a) Signature of funeral director J. H. King

(b) Address Aurora Mo.

19. (a) 2-3-41 (b) A. D. Cowan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 53

(a) State Missouri (b) County Lawrence

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

(d) Street No. 17 East Church St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 28 year 1940 hour 9 minute 00 A.M.

21. I hereby certify that I attended the deceased from May 11, 1940, to Jan 11, 1941, that I last saw him alive on Jan 11, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Ch. Coriase
Valvular Disease ?

Due to _____

Due to _____

Other conditions 92.5
(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) no

(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 R. D. Cowan (M. D. or other) D
Address Aurora, Mo. Date signed 1/28/41

RECEIVED

District Health Officer No. 6,

District File Number 141-193

Date Filed FEB 4 1941

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

Herman Swridge

Licensed Embalmer No. 3072

P. O. Address Aurora 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, fact should be so stated above.

2B
2-21-40
X22550

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

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Aurora
(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) PRINT FULL NAME Wm M 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 m

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

7. Birth date of deceased (7 Mar 1882)
(Month) (Day) (Year)

8. AGE: Years 58 Months 10 Days 27
If less than one day _____ 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 _____

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) 2-3-41 (b) R. D. Cowan M.D.
(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 Jan day 28
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____,
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 _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

