

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.

FILED MAY 21 1941

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

16198
Do not use this space.

1. PLACE OF DEATH

(a) County Worth
(b) Township Middle Fork
(c) City Worth
(e) Length of residence in city or town where death occurred 40 yrs. mos. ds.

Registration District No. 903
Primary Registration District No. 6213

Registered No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Emma Rachel Lewis

(a) Residence, No. _____ St. ☐ (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jacob L Lewis
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 3 1854
7. AGE 87 YEARS MONTHS 2 DAYS 15 If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. house wife
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio
13. NAME Wm Moore
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio
15. MAIDEN NAME Emeline Brooks
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS) Mrs Grace Hall

18. BURIAL, CREMATION, OR REMOVAL PLACE Gran. City Cem DATE April 20, 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hayes Andrews Worth Mo

20. FILED Apr. 26, 1941 Clifford Hays Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 18, 1941

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1939, to April 1, 1941.
I last saw him alive on Apr 2, 1941. Death is said to have occurred on the date stated above, at 3.30 a.m.
The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis
Bronchial Pneumonia
Date of onset unknown
10 days

Other contributory causes of importance: Impaction of bowels

Name of operation _____ Date of _____
What test confirmed diagnosis? Physical findings Where an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) Charles J. Williamson M. D.
(Address) Quincy Mo

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 Me

....., Registered Apprentice No.
working under my personal supervision.

Signed

Hayes Andrews

Licensed Embalmer No. 2892

P. O. Address Worth, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16198
Registrar's No. _____

Registration District No. 903

Primary Registration District No. 6213

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Middlefork
(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 Emma Rachel Lewis

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

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

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 87 Months 2 Days 15 If less than one day _____ hr. _____ 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Hayes Andrews

(b) Address Worth, Mo.

19. (a) July 1, 1941 (b) Clifford Hays
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Worth

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

(d) Street No. Middlefork Gap (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month apr day 18
year 1941 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 _____

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 Chas H Williamson (M.D. or other)

Address Wentz, Mo Date signed _____

SUPPLEMENTARY

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

