

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 23 1943

State File No.

Registration District No. 2193

Primary Registration District No. 5709

Registrar's No.

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

1. PLACE OF DEATH

(a) County McDonald
(b) City or town Rural Erie Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Anderson mo RFD No 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. _____ (Specify whether
In this community 30 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County McDonald
(c) City or town Anderson mo RFD No 3
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Guyette 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 Clyde Lewis
6. (c) Age of husband or wife if alive 28 years (Day) (Year)
7. Birth date of deceased Jan 22 1908 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
35 0 7 hr. min.

9. Birthplace Ark 1 (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name Jen A Lewis

13. Birthplace Ark 1 (City, town, or county) (State or foreign country)

14. Maiden name Martha Lewis

15. Birthplace Ark 1 (City, town, or county) (State or foreign country)

16. (a) Informant Jen Lewis

(b) Address Anderson mo 1943

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-43 (Month) (Day) (Year)

(c) Place: burial or cremation Cowley Cemetery

18. (a) Signature of funeral director W. C. Williams

(b) Address Anderson mo

19. (a) _____ (Date received local registrar) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 29 year 1943 hour 4 minute 15 P.M.
21. I hereby certify that I attended the deceased from Oct 15, 1942 to Jan 29, 1943; that I last saw him alive on Jan 29, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (Lobar) Duration _____

Due to Tuberculosis ✓

Due to Chronic Bacterial Endocarditis

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. P. Roberts (M. D. or other) MD

Address Linerville, mo Date signed 1-29-43

RECEIVED

District Health Officer No. 6,

District File Number 234-251

Date Filed FEB 19 1943

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6916

Registration District No.

Primary Registration District No. 5709

Registrar's No.

1. PLACE OF DEATH:

(a) County Mc Donald
(b) City or town Rural
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)

(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 Gray A Lewis

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex m

5. Color or race m

6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased.....

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

35

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).....

(Burial, cremation, or removal)

(b) Date thereof.....

(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a).....

(Date received local registrar)

(b).....

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Mc Donald
(c) City or town Rural
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July
year 1945 hour 9 minute 30 M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him/her alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Bronchial pneumonia
tuberculosis of lungs

Due to.....
Due to Chronic myocarditis 1-2 yrs.

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

Major findings:
Of operations.....

Of autopsy..... none performed

Duration 4 days

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place)
(c) Means of injury.....

23. Signature R P Roberts (M. D. or other)
Address..... Date signed.....

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

SUPPLEMENTARY

