

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 5449

FILED JAN 5 1944

Registration District No. _____ Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hosp. No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10-10-43-12-19-43
(Specify whether _____)
In this community Unknown
years, months or days

3. (a) PRINT FULL NAME CLAUDE LEWIS
3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Hazel M. Lewis 6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased November 28 1889
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 0 21 _____ hr. _____ min.

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

10. Usual occupation Unemployed

11. Industry or business _____

MOTHER FATHER { 12. Name John Lewis
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Rebecca ?
15. Birthplace Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address 1 General Hospital No. 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-43
(Month) (Day) (Year)

(c) Place: burial or cremation Nuncio Kan

18. (a) Signature of funeral director Wm Greenstadt

(b) Address 1819 E. 15

19. (a) 12-21-43 (Date received local registrar) (b) H. C. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2615 E. 24th Terr.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 19
year 1943 hour 12:25 minute A. M.

21. I hereby certify that I attended the deceased from October 10, 1943, December 19, 1943, that I last saw him alive on December 19, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Acute Congestive heart failure probably on hypertensive basis
Due to Chronic Nephritis with Uremia

Other conditions (Include pregnancy within 3 months of death) 1314

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? _____

23. Signature H. C. Brown (Specify type of place) (e) Means of injury _____
Address 1819 E. 15 (M. D. or other) _____
Date signed 12/20/43

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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.....

W. G. Flynn

Licensed Embalmer No.....

2211

P. O. Address.....

1819 E. 15th

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.