

FILED JAN 13 1948

Registration District No. 275

Primary Registration District No. 6095

Registrar's No. 105

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

1. PLACE OF DEATH:

(a) County Schuyler

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

(c) Name of hospital or institution Camp  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 63 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Schuyler

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

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

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Jane Elsworth Lewis

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 21 year 1947 hour 12 minute 15 A.M.

21. I hereby certify that I attended the deceased from Dec 8 1947, to Dec 21, 1947; that I last saw him alive on Dec 21, 1947; and that death occurred on the date and hour stated above.

4. Sex m 5. Color or Race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife Wila Lewis 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 11 30 1880  
(Month) (Day) (Year)

Immediate cause of death Cardiac Failure

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Progressive Paralysis  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

63 0 21 hr. \_\_\_\_\_ min.

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

10. Usual occupation Harmon

11. Industry or business \_\_\_\_\_

12. Name John Lewis

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

14. Maiden name Charlotte Soosey

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

16. (a) Informant Mrs. Wila Lewis

(b) Address Douning Mo.

17. (a) Burial (b) Date thereof Dec 22-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Douning Cemetery

18. (a) Signature of funeral director Loyd Moore

(b) Address Douning Mo.

19. (a) Dec 22, 1947 (b) Al Justice  
(Date received local registrar) (Registrar's signature)

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. E. Vaughn (M.D. or other) D.O.

Address Lancaster, Mo. Date signed 12/21/47

98  
0  
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MOTHER FATHER

RECEIVED  
District Health Officer No. 10  
District File Number 1-44-167  
Date Filed JAN 12 1944

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 Lloyd Moore  
Licensed Embalmer No. 31871  
P. O. Address Worthington

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.