S. No. 2
M—5-42
5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 14 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 2241

Registration District No. 46 Primary Registration District No. 5152 Registrar's No. 57

1. PLACE OF DEATH:

(a) County Caldwell

(b) City or town Polo Rural Fr. N 2 (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Caldwell

(c) City or town Polo 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 0

3. (a) PRINT FULL NAME James M. Lewis

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

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

6. (b) Name of husband or wife Rebecca Lewis 6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased Sept (Month) 6 (Day) 1865 (Year)

8. AGE: Years 78 Months 4 Days 5 If less than one day ..... hr. ..... min.

9. Birthplace Princeton (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation Farmer

11. Industry or business .....

FATHER
12. Name Henry Lewis
13. Birthplace ..... (City, town, or county) Tenn (State or foreign country)

MOTHER
14. Maiden name Sarah
15. Birthplace ..... (City, town, or county) Tenn (State or foreign country)

16. (a) Informant Sarah Lewis

(b) Address Polo Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 (Month) 13 (Day) 44 (Year)

(c) Place: burial or cremation Prairie Ridge

18. (a) Signature of funeral director Alspaugh & Cowley

(b) Address Polo Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 10th year 1944 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from December 14, 1943, to January 10, 1944, that I last saw him alive on January 10th 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia — Duration 4 days

Due to .....

Due to .....

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature Harry M. Wright (M.D. or other) D.O.

Address Polo, Mo. Date signed 1/12/44

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(Licensed Embalmer's Statement on Reverse Side)

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.

. S. No. 2B
0M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Feb.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:
(a) County: Caldwell
(b) City or town: Rural
(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 years, months or days)
In this community _____

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

3. (a) PRINT FULL NAME James 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 84 years
7. Birth date of deceased Sept. (Month) 6 (Day) 1863 (Year)
8. AGE: Years 78 Months 4 Days _____ If less than one day: _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) Mo. (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
FATHER 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
MOTHER 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) 1/31-44 (Date received local registrar) (b) Corrienne Jarrett (Registrar's signature) Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January Day 30 year 1944 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	Duration
Due to	
Due to	
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? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

2241