

FILED MAR 1 1945

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 130

1. PLACE OF DEATH:

(a) County **GREENE**  
(b) City or town **SPRINGFIELD**  
(If outside city or town limits, write "RURAL" and name of township)  
Name of hospital or institution: **SPT BAPTIST HOSPITAL**  
(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)

3. (a) PRINT FULL NAME **JAMES R. LEWIS**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color of race **WHITE** 6. (a) Single, widowed, divorced, **MARRIED**  
(b) Name of husband or wife **JENNIE LEWIS** 6. (c) Age of husband or wife if alive **82** years  
7. Birth date of deceased **UNK. UNK. 1868**  
(Month) (Day) (Year)

8. AGE: Years **77** Months **UNK.** Days **UNK.** If less than one day hr. min.

9. Birthplace **GREENE CO. MO. A**  
(City, town, or county) (State or foreign country)

10. Usual occupation **RETIRED R.R. EMPLOYEE**

11. Industry or business **LABORER; R.R. CO.**

MOTHER FATHER  
12. Name **Unknown**  
13. Birthplace **Unknown** **unk. 9**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Unknown**  
15. Birthplace **Unknown** **unk. 9**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Brock Miller**  
(b) Address **2552 Kellett, Springfield, Mo.**

17. (a) **Burial** (b) Date thereof **Feb 15-1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**GREEN LAWN, Robinson Prairie**

18. (a) Signature of funeral director **J. W. Klingner Co.**  
(b) Address **Springfield, Mo.**

19. (a) **2-15-45** (b) **J. W. Handley**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **GREENE**  
(c) City or town **Rural - SPRINGFIELD TWP. 21**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **R.F.D. #5**  
(If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country **✓**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **FEB** - day **13**  
year **1945** hour **11** minute **25 A.M.**

21. I hereby certify that I attended the deceased from **July 7, 1944** to **Feb 13, 1945**  
that I last saw him alive on **July 13, 1944**  
and that death occurred on the date and hour stated above.

Duration  
Immediate cause of death **Uremic Retention - 5 Days**  
Due to **enlarged prostate**  
Due to **Carcinoma of prostate**  
Other conditions **Genitility**  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: **✓**  
Of operations **5/8**  
Of autopsy **no 5/8**  
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 **A. T. Freeman** (M. D. or other)  
Address **Springfield** Date signed **2/13/45**

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

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**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.....

*Ogle Stone Jr.*

Licensed Embalmer No.....

*4126*

P. O. Address.....

*Springfield*

**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.)**

*T*

**If this body is not embalmed, fact should be so stated above.**