

FILED JUN 12 1945
Registration District No. 297

Primary Registration District No. 3057

Registrar's No. 35

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

1. PLACE OF DEATH:
Ray
(a) County Richmond
(b) City or town Richmond
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
532 North Main St.
(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 Beulah Faye Lewis
3. (b) If veteran, name war No
3. (c) Social Security No. 459-16-3350

4. Sex Female / 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Claude J. Lewis
6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased: Jan. (Month) 4 (Day) 1907 (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>38</u>	<u>5</u>	<u>2</u>	hr. min.

9. Birthplace Ray Co. Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation House Wife

11. Industry or business _____
12. Name Charlie A. White
13. Birthplace Ray Co. Mo.
(State or foreign country)
14. Maiden name White or Ann White
15. Birthplace Ray Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C. A. White
(b) Address Richmond. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9, 1945
(Month) (Day) (Year)
(c) Place: burial or cremation Newhope Cemetery

18. (a) Signature of funeral director [Signature]
(b) Address Richmond. Mo.

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

2. USUAL RESIDENCE OF DECEASED:
Missouri (a) State (b) County Ray
(c) City or town Richmond
(If outside city or town limits, write "RURAL")
(d) Street No. 532 North Main St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 6
year 1945 hour 5 minute 15 P. M.
21. I hereby certify that I attended the deceased from June 5
1945 to June 6, 1945;
that I last saw her alive on June 5
and that death occurred on the date and hour stated above.
Immediate cause of death: Carcinoma of breast with metastases
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy 50

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) (b) Means of injury _____
23. Signature [Signature] (M. D. or other) 6-8-45
Address _____ Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. _____

District File Number _____

Date Filed 6/11/45

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, on 6/11/45

Registered Apprentice No. _____

working under my personal supervision.

Signed E. J. [Signature]

Licensed Embalmer No. 2073

P. O. Address Richmond, Mo.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. 85

Registration District No. 297 Primary Registration District No. 3057

1. PLACE OF DEATH:

(a) County Ray Richmond
(b) City or town Ray Richmond
(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) (Specify whether

3. (a) PRINT FULL NAME Berlah F. Lewis

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

4. Sex F 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 _____ years

7. Birth date of deceased Jan 4 1945
(Month) (Day) (Year)

8. AGE: Years 38 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) June 8 1945 (b) Mrs. Chas. W. Sheppard
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 8 Year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Duration of immediate cause of death _____

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? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

17911