

STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED NOV 15 1945  
128

Primary Registration District No. 5465

Registrar's No. 859

1. PLACE OF DEATH: **GREENSB**

(a) County **GREENSB**

(b) City or town **Rural, N. Campbell Twp.**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
~~Iron Springs Sanatorium~~  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **0 Hospice**  
(Specify whether)

In this community **0 Hospice**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**

(c) City or town **Rural Springfield N. Campbell Twp.**  
(If outside city or town limits, write "RURAL")

(d) Street No. **Greene Co. FARM**  
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **DAVID MORGAN LEWIS**

3. (b) If veteran, name war **UNK.**

3. (c) Social Security No. **UNK.**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **23**  
year **1945** hour **8:** minute **30 P.M.**

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Divorced**

6. (b) Name of husband or wife **UNK.**

6. (c) Age of husband or wife if alive **UNK.** years

7. Birth date of deceased **July 4, 1862**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **October 1945** to **Oct 23 1945**  
that I last saw him alive on **Oct 23 1945**  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
✓	<b>83</b>	<b>3</b>	<b>19</b>	hr. min.

Immediate cause of death:  
**Pneumonia**  
**Arteriosclerosis, general**

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

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

Duration  
**3 da.**

9. Birthplace **Racine, Wisconsin**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Lone Pine Kennel Club**

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

Of autopsy **107**

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

MOTHER FATHER

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

12. Name **R. M. Lewis**

13. Birthplace ~~Wales~~ **UNK.** **Wales**  
(City, town, or county) (State or foreign country)

14. Maiden name **Jane Jones**

15. Birthplace ~~Wales~~ **UNK.** **Wales**  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant **D. M. Lewis**

(b) Address **Minder Louisiana**

17. (a) **Removal** (b) Date thereof **10/26/1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Racine, Wisconsin**

18. (a) Signature of funeral director **Alma Lohmeyer Funeral Home**

(b) Address **534 St. Louis Street, Springfield, Mo.**

19. (a) **10-26-45** (b) **J. W. Handley**  
(Date received local registrar) (Registrar's signature)

23. Signature **James P. Wood** (M. D. or other) \_\_\_\_\_

Address **Springfield, Mo.** Date signed **10-26-45**

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.....

*Lewis G. Schopf*

Licensed Embalmer No. 3802

P. O. Address.....

*Springfield, 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.**

X