

7. S. No. 2  
DOM-5-43  
Rev. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39441

State File No.

FILED DEC 21 1945  
318

Registration District No.

Primary Registration District No.

1002

Registrar's No.

10735

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: PARK LANE HOSP.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 DAY (Specify whether  
In this community 1 DAY  
years, months or days)

3. (a) PRINT FULL NAME

ELIZABETH M. LEWIS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife JOHN LEWIS

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

7. Birth date of deceased DEC. 5 1876  
(Month) (Day) (Year)

8. AGE:

Years 69 Months 0 Days 3

If less than one day hr. min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business

12. Name JOHN O'KELLEY

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

14. Maiden name MARINDIA OWENS

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

16. (a) Informant William Owen Lewis

(b) Address 9733 Diamond Dr.

17. (a) Removal (b) Date thereof DEC. 12 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NORTH LITTLE ROCK ARK.

18. (a) Signature of funeral director Diedrich Funeral Home

(b) Address 8319 Halls Ferry Rd.

19. (a) DEC 20 1945 (b) J. F. Brecken  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County St. Louis  
(c) City or town RIVERVIEW GARDENS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 9733 Diamond Dr., NR  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 8  
year 1945 hour 2 minute P. M.

21. I hereby certify that I attended the deceased from Dec 6 1945 to Dec 8 1945  
that I last saw her alive on Dec 8 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary embolism  
Due to Thromboses  
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 W. A. ... (M. D. or other)  
Address 2201 N. Broadway Date signed

Duration

2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

299

**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

*John Ogowski*

Licensed Embalmer No. *3398*

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.**