

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 31 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7671**
Registrar's No. **1949**

Registration District No. _____ Primary Registration District No. **100.3**

1. PLACE OF DEATH:
(a) County **St. Louis Mo**
(b) City or town **St. Louis**
(c) Name of hospital or institution **St. Louis**
(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** County **St. Louis**
(c) City or town **St. Louis**
(d) Street No. **3225 Montgomery**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Thomas Lewis**
(b) If veteran, name war _____ (c) Social Security No. _____
4. **Married** 5. Color **White** 6. (g) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan** day **21** year **1946** hour **4** minute **10** am. M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)
8. AGE: **47** Years **11** Months **1** Days If less than one day _____ hr. _____ min.

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death **Terminal stage of heart failure** Duration _____
known he fell in the bathroom
Due to **of the bath room at City Hotel**
on Dec 14-1945 about 2 1/2 hrs
Due to **Accident**

9. Birthplace **New York** (City, town, or county) **N.Y.** (State or foreign country)
10. Usual occupation **Bus Driver**
11. Industry or business **Bus**

Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

MOTHER FATHER
12. Name **Ann K. Lewis**
13. Birthplace **New York** (City, town, or county) **N.Y.** (State or foreign country)
14. Maiden name **Ann K. Callahan**
15. Birthplace **New York** (City, town, or county) **N.Y.** (State or foreign country)
16. (a) Informant **Thos. J. Callahan**
(b) Address **1300 12th St**
17. (a) **Anatomical Board** (b) Date the body was disposed of **27-46**
(c) Place: burial or cremation **Washington**
18. (a) Signature of funeral director **J. J. Brubaker**
(b) Address **2500 Rutledge**
19. (a) **FEB 27 1946** (b) **J. J. Brubaker**

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) **Accident**
(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? _____
White at work? _____ (Specify type of place) (e) Means of injury **?**
23. Signature **Robert E. Doyle** (M. D. or other) _____
Address **249 W. 11th** Date signed **2/21/46**

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.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Mar
Registrar's No. 1949

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St. Louis
(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)

3. (a) PRINT FULL NAME Thomas 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.....

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 41 Months 7 Days 1 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) (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) (Date received local registrar) (b) (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 January, year 1949 hour 10 minute 00 A.M.

21. I hereby certify that I attended the deceased from..... 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 Fracture of left femur

status: Terminal

When he fell to the floor of the ball

room at City Hospital on May 14

1948 about 3:00 P.M. Clark G.W.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Accident

(b) Date of occurrence May 14 1948

(c) Where did injury occur? at home (City or town) (County) (State)

(d) Did injury occur in or about home, or farm, in industrial place, in public place? Home

(Specify type of place)

(e) Means of injury as above

While at work? No

23. Signature Patricia E. Taylor (M. D. or other)

Address 144 E. 14th St. Date signed 3/29/49

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

SUPPLEMENTARY

7671