. S. No. 2
OM—1/47
ev. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUL 15 1947

Registration District No. 2

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 22974

Registrar's No. 1491

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since 5/26/47 (Specify whether
In this community 12 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 100
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 2209 Market St. 9
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME LEWIS, Leon
3. (b) If veteran, name war World War I
3. (c) Social Security No. 284 18 0310
4. Sex male 2
5. Color or race negro
6. (a) Single, widowed, married, divorced Single ( )
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased December 14, 1892
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
55	6	23	hr. min.

9. Birthplace Mississippi 1
(City, town, or county) (State or foreign country)
10. Usual occupation Waiter
11. Industry or business

FATHER
12. Name Green Lewis
13. Birthplace Mississippi 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Registrar, Vet. Adm. Hospital,
(b) Address Jefferson Barracks, Mo.
17. (a) Burial (b) Date thereof 7/11/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation National Cemetery
18. (a) Signature of funeral director Gates Funeral Home
(b) Address 4107 West Finney, St. Louis, Mo.
19. (a) 7-11-47 (b) Cecila J. Sharp MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7
year 1947 hour 9:55 minute A M.

21. I hereby certify that I attended the deceased from May 26, 1947, 19, to July 7, 1947, 19;
that I last saw him alive on July 7, 1947, 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death BRONCHOGENIC CARCINOMA, LEFT	
Due to	
Due to 47 c	
Other conditions PULMONARY TUBERCULOSIS, OLD ARRESTED (Include pregnancy within 3 months of death)	

Major findings:
Of operations No/Oo Bronchoscopy 6/14/47
Of autopsy No Autopsy

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature L. E. Stilwell (M. D. or other)
Address Vet. Adm. Hosp., Jeff. Bks. MO Date signed 7/8/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Thomas J. Gates, Registered Apprentice No. ____, working under my personal supervision.

Signed Thomas J. Gates

Licensed Embalmer No. 4259

P. O. Address 4107 Fir

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.