

S. No. 2  
M-8-43  
7-5-17-39.  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24260

FILED AUG 5 1947

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2993

1. PLACE OF DEATH:

(a) County JACKSON  
(b) City or town KANSAS CITY  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
GENERAL HOSPITAL NO. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 HRS.  
(Specify whether  
In this community 30 YRS.  
years, months or days)

3. (a) PRINT FULL NAME BENNIE LEWIS

3. (b) If veteran, name war No 3. (c) Social Security No. 495-10-1648

4. Sex MALE 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Maggie Lewis 6. (c) Age of husband or wife if alive Unk years

7. Birth date of deceased January 17 1890  
(Month) (Day) (Year)

8. AGE: Years 57 Months 511 Days 25 If less than one day hr. min.

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

10. Usual occupation LABORER

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

MOTHER FATHER { 12. Name ALLEN LEWIS  
13. Birthplace VIRGINIA  
(City, town, or county) (State or foreign country)  
14. Maiden name ALICE WAGNER  
15. Birthplace MISSISSIPPI  
(City, town, or county) (State or foreign country)

16. (a) Informant ANDERSON LEWIS (BROTHER)

(b) Address 2112 VINE STREET

17. (a) Burial (b) Date thereof 7/16/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director Watford Boyd

(b) Address 1729 S. York Avenue

19. (a) 7-15-47 (b) Delphine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48  
(c) City or town KANSAS CITY 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1107 E. 17TH ST. F  
(If rural, give location) 0  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 12,  
year 1947 hour 8: minute 15 P. M.

21. I hereby certify that I attended the deceased from JULY  
12, 1947 to JULY 12, 1947  
that I last saw him alive on JULY 12, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death INTESTINAL OBSTRUCTION Duration \_\_\_\_\_

Due to carcinoma of colon

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) 46 e

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

Of autopsy SAME AS ABOVE

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?

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (a) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) M. D.  
Address GENERAL HOSPITAL NO. 2 Date signed 7/14/47

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

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**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.**