

FILED OCT 20 1947
Registration District No. 3474

Primary Registration District No. 4547

Registrar's No. 104

1. PLACE OF DEATH:

(a) County Worth

(b) City or town Grant City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 51 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Katherine 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, widowed

6. (b) Name of husband or wife Nelson I. Lewis

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

7. Birth date of deceased Feb. 21, 1855
(Month) (Day) (Year)

8. AGE: Years 92 Months 7 Days 7 If less than one day
hr. _____ min. _____

9. Birthplace Wooster Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

12. Name Alexander McQuade

13. Birthplace Wooster, Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Mary Bigham

15. Birthplace Wooster, Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nettie Hiatt

(b) Address Grant City, Mo.

17. (a) Burial (b) Date thereof 9-30-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grant City, Mo

18. (a) Signature of funeral director Arch C. Dunfer

(b) Address Grant City, Mo.

19. (a) Oct 11-1947 (b) Leta E. Dawson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Worth

(c) City or town Grant City, MO
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28
year 1947 hour 9 minute _____ P. M.

21. I hereby certify that I attended the deceased from Aug 15 1947 to Sept 28 1947
that I last saw her alive on 27 Sept 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Cardiovascular Disease Duration 5-6 yrs

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy 9329

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) _____

(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 Frank B. Nathan M.D.
Address Grant City, Mo Date signed 30 Sept 1947

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

13
10

MAY 25 1948

MAY 25 1948

NOV 3 1948

JUL 7 1948

NOV 13 1953

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *Arch C. Dumble*.....

Licensed Embalmer No. *3252*.....

P. O. Address *Grant City, 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.