

No. 2
5-43
17-39
X36671

FILED DEC 12 1947

Registration District No. **247**

Primary Registration District No. **4573**

Registrar's No. **30**

1. PLACE OF DEATH:

(a) County **SULLIVAN**
(b) City or town **GREEN CASTLE**
(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 **—**
In this community **Life**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Sullivan**
(c) City or town **Green Castle**
(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 **—**

3. (a) PRINT FULL NAME **Charles Wagner Lewis**

3. (b) If veteran, name war **—** 3. (c) Social Security No. **—**

4. Sex **Male** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **M.**
6. (b) Name of husband or wife **Ella Lewis** 6. (c) Age of husband or wife if alive **—** years
7. Birth date of deceased **4 14 1862**
(Month) (Day) (Year)

8. AGE: Years **85** Months **7** Days **19** If less than one day hr. min.

9. Birthplace **Pouilville Ky.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Medical Doctor**

11. Industry or business

MOTHER FATHER { 12. Name **Joseph Lewis**
13. Birthplace **—**
(City, town, or county) (State or foreign country)
14. Maiden name **Don't know**
15. Birthplace **Don't know**
(City, town, or county) (State or foreign country)

16. (a) Informant **Jim Williams**

(b) Address **Green Castle Mo.**

17. (a) **Burial** (b) Date thereof **12-5-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Castle Mo.**

18. (a) Signature of funeral director **Wm. E. Kent**

(b) Address **Green City Mo.**

19. (a) **12-5-1947** (b) **—**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **2**
year **1947** hour **12** minute **10 a.** M.

21. I hereby certify that I attended the deceased from **Dec 1** 1947 to **Dec 2** 1947
that I last saw him alive on **Dec 1** 1947
and that death occurred on the date and hour stated above.

Immediate cause of death **Old age and Mal Nutrition and Nephritis**

Due to **—**
Due to **—**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **12.2**
Of autopsy **12.2**

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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. Huntington MD** (M. D. or other)

Address **Green City Mo.** Date signed **12-5-47**

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

RECEIVED
District Health Officer No.
File Number 12-47-17
Date Filed DEC 10 1947

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec
Registrar's No. 30

Registration District No. 349 Primary Registration District No. 4513

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Sheep Castle
(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 Charles W. 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 m

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

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

8. AGE: Years 85 Months _____ Day _____ 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) 12-5-47 (Date received local registrar) (b) Louie Showl (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 _____ Year _____ Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him/her alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Chronic Hepatitis

Due to _____

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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