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FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics  
FILED NOV 1 1948  
MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

33212

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

Registration District No. 147

Primary Registration District No. 5569  
1002

Registrar's No. 316

1. PLACE OF DEATH:  
(a) County JACKSON  
(b) City or town HANSAAS CITY  
(c) Name of hospital or institution: Manchester n. 40 Highway 3  
(d) Length of stay: In hospital or institution 54 RS  
In this community 54 RS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI County JACKSON  
(c) City or town HANSAAS CITY  
(d) Street No. 5619 E. 35th TERR.  
(e) Citizen of foreign country? No.

3: (a) PRINT FULL NAME COMMIE LEE LEWIS  
3. (b) If veteran, name war No.  
3. (c) Social Security No. 438-27-1016

20. DATE OF DEATH: Month 10 day 1 year 1948 hour 9 minute 45 P. M.  
21. I hereby certify that I attended the deceased from Deputy Coroner  
that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above.

4. Sex Male  
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 JAN 7, 1928 (Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 10 day 1 year 1948 hour 9 minute 45 P. M.  
21. I hereby certify that I attended the deceased from Deputy Coroner  
that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above.

8. AGE: Years 21 Months - Days - If less than one day hr. min.

Immediate cause of death Shock  
Due to Cerebral Hemorrhage  
Due to Compound-fractured Skull  
Other conditions (Include pregnancy within 3 months of death)

9. Birthplace Pelican, La.  
10. Usual occupation Hod Carrier  
11. Industry or business CONSTRUCTION WORK

Major findings: 1900  
Of operations \_\_\_\_\_  
Of autopsy No - Permit  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
12. Name FRANK LEWIS  
13. Birthplace Pleasant Hill, La.  
14. Maiden name SIRLENA TURNER  
15. Birthplace Pelican, La.

16. (a) Informant MRS. SIRLENA BRADLEY  
(b) Address 3602 Brookcrest  
17. (a) Removal (b) Date thereof 10-5-48  
(c) Place: burial or cremation Mansfield, La.

22. If death was due to external causes, fill in the following:  
(a) (Accident) suicide, or homicide (specify) Auto-Trauma  
(b) Date of occurrence 10-1-48  
(c) Where did injury occur? K.C. Jackson - Mo.  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? To gluyay - 40  
While at work (Specify type of place) (e) Means of injury Auto-Trauma  
23. Signature McMillan (M. D. or other)  
Address 3636 Brookcrest Date signed

18. (a) Signature of funeral director G. L. Orama  
(b) Address 1513 Brookcrest  
19. (a) 10-5-48 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

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

FEB 14 1949

EXHIBIT AON

**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 C. E. Davis

Licensed Embalmer No. 4417

P. O. Address R. C. M.

**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. Nov  
Registrar's No. 826

Registration District No. 146 Primary Registration District No. 5568

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Cuba - Blue  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Manchester - N. 40 Highway  
(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 Carmie Lee Lewis  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced 5  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

8. AGE: Years 20 Months 8 Days 20 (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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Specify type of place)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) Nov 6, 1948 (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (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 Nov year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ 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 \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
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) \_\_\_\_\_  
(b) Date of occurrence 10-1-48  
(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? Highway 40  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury auto  
23. Signature J. R. Williams (M.D. or other) \_\_\_\_\_  
Address 2636 Broadway (City and County)

SUPPLEMENTARY

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

5-33212