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FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **36096**

FILED DEC 15 1948

Registration District No. 116

Primary Registration District No. 3020

Registrar's No. 147

1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town Washington  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Francis Hospital.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day.  
In this community 60 years.  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Emma Lewright.  
3. (b) If veteran, name war X  
3. (c) Social Security No. None.

4. Sex Female / 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband James T. Lewright  
6. (c) Age of husband or wife if alive deceased years  
7. Birth date of deceased: November 28th, 1864  
(Month) (Day) (Year)

8. AGE: Years 84 Months 0 Days 4  
If less than one day hr. min.

9. Birthplace: Union, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation: House work, House Maker

11. Industry or business: X

MOTHER FATHER { 12. Name Frederick Reinhard,  
13. Birthplace Unknown, Germany  
14. Maiden name Pauline Drees,  
15. Birthplace Union, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Eugene Lewright  
(b) Address Washington, Mo.

17. (a) Burial (b) Date thereof Dec. 5, 1948.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union, Mo.

18. (a) Signature of funeral director Nielburg & Vitt, Inc.

(b) Address Washington, Mo.

19. (a) Dec 4, 1948 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin  
(c) City or town Washington  
(If outside city or town limits, write "RURAL")  
(d) Street No. 317 E. 5th St.  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 2nd,  
year 1948 hour 4:00 minute 10 P. M.

21. I hereby certify that I attended the deceased from Nov 16, 1948, to Dec 2, 1948  
that I last saw her alive on Dec 2, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death acute myocarditis Duration 1 day  
Due to Gastro. enteritis 1 mo

Due to \_\_\_\_\_  
Other conditions Senility - Arteriosclerosis  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy 93a  
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) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M, D, or other) Nov  
Address Mad & Elm St Washington Mo Date signed 12-3-48

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

RECEIVED  
District Health Officer No. 9,  
District File No. DEC 13 1948  
Date Filled

**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..... *Lester A. Witt*

Licensed Embalmer No. *3254*

P. O. Address *Washington, DC*

**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.