

FILED JUL 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18795

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 220

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Callaway Boone Co</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>	
c. LENGTH OF STAY (in this place) <u>14 1/2 Mo</u>		d. STREET ADDRESS (If rural, give location) <u>-</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>State Hospital No 1</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Martha Lewis</u>	b. (Middle) <u>-</u>	c. (Last) <u>Lewis</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>6 28- 1949</u>
-------------------------------------	--------------------------------	----------------------	------------------------	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-6-1885</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>22</u>	IF UNDER 4 HRS. Hours <u>-</u> Min. <u>-</u>
----------------------	---------------------------------	--	-------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
---	---	--	---

13a. FATHER'S NAME <u>Frank Whitter</u>	13b. MOTHER'S MAIDEN NAME <u>D. K.</u>	14. NAME OF HUSBAND OR WIFE <u>D. K.</u>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Hospital records, Fulton, Mo</u>	ADDRESS <u>-</u>
---	--	--	---------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 K</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Paralysis</u> <u>meningitis</u> <u>cephalitis</u> <u>right side</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c): _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>025X</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	-----------------------------------	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from _____, 19____, to 6-28, 1949, that I last saw the deceased alive on 6-27-49, 1949, and that death occurred at 4:15A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>M. D. C. Miller, M.D.</u>	23b. ADDRESS <u>State Hospital No. 1 Fulton, Mo</u>	23c. DATE SIGNED <u>6-28-49</u>
--	--	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June-30-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Columbia Mo.</u>
--	----------------------------------	---	--

DATE REC'D BY LOCAL REG. <u>June 28-1949</u>	REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Shawnee Taylor</u>	ADDRESS <u>Columbia, Mo.</u>
---	--	---	---------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

14
2

District File Number _____

District Health Officer No. 9

RECEIVED JUL 6 1949

JUL 27 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Stewart Parker

Licensed Embalmer No. 2900

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.