.300
.48

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

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25048

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6607

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St Louis
c. LENGTH OF STAY (In this place): 10yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION: STlouis State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: not 17
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): STlouis 9
d. STREET ADDRESS (If rural, give location): 4020 Castleman

3. NAME OF DECEASED (Type or Print)
a. (First): MAURICE
b. (Middle):
c. (Last): LEWIS

4. DATE OF DEATH (Month) July (Day) 17th (Year) 1949

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 11-5-1898
9. AGE (In years last birthday): 50 | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unk
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mo
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: unk
13b. MOTHER'S MAIDEN NAME: unk
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Hosp Records
ADDRESS: STlouis mo

MEDICAL CERTIFICATION

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.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yrx

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Generalized Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

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) 97 (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 4200

22. *I hereby certify that I attended the deceased from* Jan. 1, *19* 48, *to* July 17, *19* 49, *that I last saw the deceased alive on* July 17, *19* 49, *and that death occurred at* 6.17p *m., from the causes and on the date stated above.*

23a. SIGNATURE: Paul T. Hartung (Degree or title) M.D.
23b. ADDRESS: 5400 Arsenal St.
23c. DATE SIGNED: July 8 '49

24a. BURIAL, CREMATION, REMOVAL (Specify):
24b. DATE: 8-1-49
24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.: 7-31-49
REGISTRAR'S SIGNATURE: J. B. Lacater

25. FUNERAL DIRECTOR'S SIGNATURE: Rowland Funeral Service Inc.
ADDRESS: 4104 Manchester Ave. St. Louis 10, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.