

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29711

State File No.

D. Bruce
FILED SEP 29 1949

BIRTH NO. _____ REG. DIST. NO. 80 PRIMARY REG. DIST. NO. 5306 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Callaway County</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Elston</u>	c. LENGTH OF STAY (in this place) <u>17 months</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Cedar City MO</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>At Home - Elston, Mo.</u>		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <u>MINNIE</u>	b. (Middle) <u>M.</u>	c. (Last) <u>Lewis</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 18 1949</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>Sept 25-1890</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>29</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Callaway Co. MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
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13a. FATHER'S NAME <u>James P. Lewis</u>	13b. MOTHER'S MAIDEN NAME <u>ANNA E. Dougherty</u>	14. NAME OF HUSBAND OR WIFE <u></u>
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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>no</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Jack Meng</u>	ADDRESS <u>Cedar City, Mo</u>
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio-Sclerosis</u>		
DUE TO (c) <u>Diabetes Mellitus</u>		331X	
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	19. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from June 8, 1949 to Sept 18, 1949, that I last saw the deceased alive on Aug 29, 1949 and that death occurred at 2 P. M., from the causes and on the date stated above.

23a. SIGNATURE <u>D. Bruce MDCM</u>	(Degree or title)	23b. ADDRESS <u>234 Madison Jefferson City, Mo</u>	23c. DATE SIGNED <u>9/19/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>Sept 20 - 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Meng Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>West Hart Summit MO</u>
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DATE REC'D BY LOCAL REG. <u>Sept. 20</u>	REGISTRAR'S SIGNATURE <u>Mrs. Minnie Hittner</u>	40	25. FUNERAL DIRECTOR'S SIGNATURE <u>Jack - Clayton</u>	ADDRESS <u>See New Bloomfield MO</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

26
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District File Number _____
District Health Officer No. 9
RECEIVED SEP 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 _____

LeRoy Claypool

Licensed Embalmer No. 4412

P. O. Address New Bloomfield

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.