

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 5 1951

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 5134 Registrar's No. 93

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph - rural		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph, Rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION Washington Twsp.		d. STREET ADDRESS (If rural, give location) R.F.D. # 6,	

3. NAME OF DECEASED (Type or Print) a. (First) VIOLET b. (Middle) LOUISE c. (Last) LEWELLEN			4. DATE OF DEATH (Month) (Day) (Year) 1 27 1951		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 6-4-1915			9. AGE (In years last birthday) 35		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Warfensburg, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Roam Lakey		13b. MOTHER'S MAIDEN NAME Parrie Compton		14. NAME OF HUSBAND OR WIFE Bolen Lee Lewellen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Bolen Lee Lewellen, R.F.D. # 6, ADDRESS	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 7 mo	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Carcinoma of Cervix uteri		5 yrs	
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		176 X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Emaciation; jaundice due to liver metastasis		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)		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 April 18 1950, to Jan 27, 1951, that I last saw the deceased alive on Jan 25, 1951, and that death occurred at 4:20 A.M., from the causes and on the date stated above.

23a. SIGNATURE Dr. Grant M.D.		(Degree or title)		23b. ADDRESS St. Joseph, Mo	
23c. DATE SIGNED 1-27-51					

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-29-1951		24c. NAME OF CEMETERY OR CREMATORY Memorial Park	
24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.					

DATE REC'D BY LOCAL REG. Jan 29, 1951		REGISTRAR'S SIGNATURE Carl C. Casper		25. FUNERAL DIRECTOR'S SIGNATURE (Signature) ADDRESS St. Joseph, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FLA 5 1951

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

working under my personal supervision.

Signed.....
Student Embalmer

Signed *John E. Rupp*
Student Embalmer No.
Licensed Embalmer No. *3986*

P. O. Address *St. Joseph, Mo*

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.