

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

353336

State File No.
Registrar's No. 9560

FILED NOV 8 1951

318

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BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3428 Clark Ave.		d. STREET ADDRESS (If rural, give location) 3428 Clark Ave.	

2189

3. NAME OF DECEASED (Type or Print)	s. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Florence			Lewis	10 - 26 - 1951

5. SEX Female	6. COLOR OR RACE Colred	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 8, 1895	9. AGE (In years last birthday)	# UNDER 1 YEAR	# UNDER 1 MRS. Hours	# UNDER 1 MRS. Min.
3				56			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Forest City, Arkansas	12. CITIZEN OF WHAT COUNTRY? USA.
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13a. FATHER'S NAME Tom Mooney	13b. MOTHER'S MAIDEN NAME Alice Weatherall	14. NAME OF HUSBAND OR WIFE Robert Lewis
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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) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Robert Lewis	ADDRESS 3428 Clark Ave.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Haemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours 4 years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis		
	DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Haemorrhage Feb 27th 1951		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. 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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 281X
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22. I hereby certify that I attended the deceased from **Jan 1st 1951**, to **Oct 26, 1951**, that I last saw the deceased alive on **Oct 12, 1951** and that death occurred at **8:10 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. J. Gallagher	23b. ADDRESS 3903 Olive St.	23c. DATE SIGNED 10/29/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVALS	24b. DATE 10-29-1951	24c. NAME OF CEMETERY OR CREMATORY FOREST CITY	24d. LOCATION (City, town, or county) (State) ARKANSAS
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DATE REC'D BY LOCAL REG. OCT 29 1951	REGISTRAR'S SIGNATURE Earl Smith	25. FUNERAL DIRECTOR'S SIGNATURE W.J. Baker & Son Funeral Home	ADDRESS 3201 N. Newstead Ave.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 4740th Temple

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.