

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **2750**BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **308** PRIMARY REG. DIST. NO. **4454** Registrar's No. **1**

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b>	
b. CITY OR TOWN <b>Auguste Mo</b>	c. LENGTH OF STAY (in this place) <b>life</b>	c. CITY OR TOWN <b>Auguste Mo 09<sup>th</sup> St</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <b>JOHN</b> b. (Middle) <b>D</b> c. (Last) <b>LEWIS</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 8 - 1953</b>							
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Apr. 6 1869</b>	9. AGE (In years last birthday) <b>83</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Rail Road</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>

13a. FATHER'S NAME <b>Myron Lewis</b>	13b. MOTHER'S MAIDEN NAME <b>Hant Kraw</b>	14. NAME OF HUSBAND OR WIFE <b>Bessie Lewis</b>
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. <b>489-18-1337</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Bessie Lewis</b> ADDRESS <b>Auguste Mo</b>

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>7</b>  <b>4 yr</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary thrombosis</b>	DUE TO (b) <b>Chf myocarditi</b>	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <b>Atherosclerosis</b>		
	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 <b>4201</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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?
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22. I hereby certify that I attended the deceased from **May 1950**, to **Jan 18, 1953**, that I last saw the deceased alive on **Jan 8, 1953**, and that death occurred at **9-10 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>M. Johnson</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>Northville Mo</b>	23c. DATE SIGNED <b>1/10/53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>1-11-53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Auguste Mo</b>
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DATE REC'D BY LOCAL REG. <b>Jan 10, 1953</b>	REGISTRAR'S SIGNATURE <b>Mrs. Viola Thuesen</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Olie Thelving</b> ADDRESS <b>Auguste Mo</b>
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**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 Howard O. Kinsler

Licensed Embalmer No. 4631

P. O. Address Wentzville, 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.