

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 28 1955

No. 300
10.48

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 186

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. CITY OR TOWN <u>Springfield</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>2 days</u>		e. STREET ADDRESS (If rural, give location) <u>2108 North Ramsey</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Birge Hospital</u>		0396	
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>Frank</u> c. (Last) <u>Lewis</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 25 1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb 24 1875</u>
9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer - self-employed</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Lewis County, Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>James Jackson Lewis</u>	13b. MOTHER'S MAIDEN NAME <u>Cosby Jane Mcquire</u>	14. NAME OF HUSBAND OR WIFE <u>Clara Ruth Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>70 -</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Clara Ruth Lewis</u> ADDRESS <u>2108 N. Ramsey Springfield, Mo.</u>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic heart disease</u> ANTECEDENT CAUSES DUE TO (b) <u>Generalized arteriosclerosis</u> 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 <u>4200</u>	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 <u>Feb 20, 1955</u> , to <u>Feb 25, 1955</u> , that I last saw the deceased alive on <u>Feb 24, 1955</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>W. Dean Cunningham M.D.</u> (Degree or title)		23b. ADDRESS <u>1715 Coonville Springfield, Mo.</u>	23c. DATE SIGNED <u>2-25-55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2-27-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mapleview</u>	24d. LOCATION (City, town, or county) (State) <u>Buffalo Mo.</u>
DATE REC'D BY LOCAL REG. <u>2-25-55</u>	REGISTRAR'S SIGNATURE <u>Black Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Jones</u> ADDRESS <u>Buffalo Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *Lernard B. S. meo*.....

Licensed Embalmer No. *256*

P. O. Address *Buffalo*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.