

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24035

State File No. 6270

FILED AUG 2 - 1955

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|--|----------------------------------|--|--|--|--|---|--------------------------------|
| BIRTH NO. | | REG. DIST. NO. | | PRIMARY REG. DIST. NO. | | Registrar's No. | |
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Missouri b. COUNTY Franklin | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. | | c. LENGTH OF STAY (In this place) | | c. CITY OR TOWN Washington | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL | | | | e. STREET ADDRESS (If rural, give location) 317 East 5th St | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Eugene b. (Middle) Raymond c. (Last) Lewright | | | 4. DATE OF DEATH (Month) (Day) (Year) July 18, 1955 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married | 8. DATE OF BIRTH Oct 5, 1892 | | 9. AGE (In years last birthday) 62 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker | | 10b. KIND OF BUSINESS OR INDUSTRY Banking | | 11. BIRTHPLACE (City and State or Foreign Country) Washington Mo | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME James Lewright | | 13b. MOTHER'S MAIDEN NAME Emma Reinhard | | 14. NAME OF HUSBAND OR WIFE None | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 494-32-1955 | | 17. INFORMANT'S SIGNATURE OR NAME Ralph Lewright | | ADDRESS Washington Mo. | |
| 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) Bronchogenic Carcinoma | | | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs. | | | |
| ANTECEDENT CAUSES (primary site - left lung) | | | | DUE TO (b) with metastases to liver | | | |
| Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | 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 162x | | | | 20. AUTOPSY? YES <input checked="" 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) m. | | 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 July 9, 1955 , to July 18, 1955 , that I last saw the deceased alive on July 18, 1955 , and that death occurred at 11:30 a.m. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) FR Bradley | | | | 23b. ADDRESS BARNES HOSPITAL | | 23c. DATE SIGNED 7/18/55 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 7-18-55 | 24c. NAME OF CEMETERY OR CREMATORY City | | 24d. LOCATION (City, town, or county) (State) Union, Mo. | | |
| DATE REC'D BY LOCAL REG. JUL 20 1955 | | REGISTRAR'S SIGNATURE [Signature] | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd. | | | |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

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 *John J. Haines*.....
Licensed Embalmer No.....
P. O. Address *St. Louis*.....

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.