

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 14 1955

State File No. 30155

BIRTH NO. _____		REG. DIST. NO. <u>200</u>		PRIMARY REG. DIST. NO. <u>5725</u>		Registrar's No. <u>171</u>	
1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Oklahoma</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Hudson twm.</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>Tulsa</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Still-Hildreth Sanatorium</u>				e. STREET ADDRESS (If rural, give location) <u>1527. Alanta (South) #358</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Louis</u>		b. (Middle) <u>D.</u>		c. (Last) <u>Lewk</u>	
4. DATE OF DEATH		(Month) <u>Sept</u>		(Day) <u>14</u>		(Year) <u>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>May 27, 1878</u>	
9. AGE (In years last birthday)		If UNDER 1 YEAR Months <u>77</u> Days <u>5</u>		If UNDER 1 YEAR Hours <u>17</u> Min. _____		11. BIRTHPLACE (City and State or Foreign Country) <u>San Francisco, Calif.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>Mortz Lewkowitz</u>	
13b. MOTHER'S MAIDEN NAME <u>unkown</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Ida B. Lewk</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Ida B. Lewk, Tulsa Okl.</u>		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, asthma, etc. It means the disease, injury, or complication which caused death.			
MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive circulatory failure</u>				<u>12 hrs.</u>			
ANTECEDENT CAUSES <u>Prolonged recumbency Necessitated by</u> <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Chronic involuntional recurring depression</u>				<u>9 yrs.</u>			
DUE TO (c) <u>arteriosclerosis</u> <u>4500</u>				<u>25 yrs.</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Schizophrenia</u>							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>none</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I attended the deceased from <u>Aug 23, 1955</u> to <u>Sept 13, 1955</u> , that I last saw the deceased alive on <u>Sept 13, 1955</u> , and that death occurred at <u>6:10 A.M., 9/14/55</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>R. H. Starr</u> (Degree or title) <u>D.O.</u>				23b. ADDRESS <u>Macon, Mo.</u>		23c. DATE SIGNED <u>Sept 14, 55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>Sept 14, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Tulsa, Okl.</u>	
DATE REC'D BY LOCAL REG. <u>9-14/55</u>		REGISTRAR'S SIGNATURE <u>Paul M. Neely</u> 1955		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Jester Bram</u>		ADDRESS <u>Macon, Mo.</u>	

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

NOV 7 1955

RECEIVED 10.11.55
MACON COUNTY HEALTH DEPARTMENT
County File No. 10.55.169
Date Filed 10.13.55

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.....
R. Lester Brewer

Licensed Embalmer No. 44

P. O. Address *Macon*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.-(F 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.