

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35822**  
Registrar's No. **9874**

FILED NOV 16 1956

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>CUMBERLAND</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		c. LENGTH OF STAY (in this place) <b>2 DAYS</b>	c. CITY OR TOWN <b>GREENUP</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CHILDRENS HOSPITAL</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) <b>Route #1</b>		<b>81208</b>	
3. NAME OF DECEASED (Type or Print)	a. (First) <b>KEITH</b>	b. (Middle) <b>ALLEN</b>	c. (Last) <b>LEWIS</b>
4. DATE OF DEATH	(Month) <b>10</b>	(Day) <b>27</b>	(Year) <b>1956</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>10-25-1956</b>
9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>MATTOON, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>ALBERT LEWIS</b>	13b. MOTHER'S MAIDEN NAME <b>MARGARET KEMPER</b>	14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>W. Warner - St. Louis Children's Hospital</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>PULMONARY ARTERIOSCLEROSIS + EDEMA.</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>DUCE TO (b) LEFT PNEUMAL EFFUSION.</b> <b>DUCE TO (c) POST OPERATIVE TRACHEOESOPHAGEAL FISTULA REPAIR.</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>CONGENITAL MALFORMATION OF HEART</b>		INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION <b>10/26/56.</b>	19b. MAJOR FINDINGS OF OPERATION <b>TRACHEO-ESOPHAGEAL FISTULA.</b>		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 <b>10-25-56</b> , 19___, to <b>10-27-56</b> , 19___, that I last saw the deceased alive on <b>10-27-56</b> , 19___, and that death occurred at <b>5 P.</b> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>W. Klingberg MD.</b>	23b. ADDRESS <b>500 So. Kings Highway</b>	23c. DATE SIGNED <b>10-27-56</b>	
24a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Harmony</b>	24b. DATE <b>10/29/1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>	24d. LOCATION (City, town, or county) (State) <b>Greenup, Illinois</b>
DATE REC'D BY LOCAL REG. <b>OCT 29 1956</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Chas E Allen Greenup, Ill.</b>	

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 Chas....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Chas E Shea.....  
Illinois  
Licensed Embalmer No. 565  
P. O. Address Greenville.....

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.