Health, Welfare Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-019106
STATE FILE NUMBER

FILED JUN 9 1958 Registration District No. 237 Primary Registration District No. 4356 Registrar's No. 16

1. PLACE OF DEATH
a. COUNTY New Madrid
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Parma — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Length of stay in Ib

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY New Madrid
c. CITY OR TOWN Parma 0728 0 — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Ida Middle Ines Last Lewis

4. DATE OF DEATH Month May Day 17 Year 1958

5. SEX F 1
6. COLOR OR RACE cauc.
7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Mar. 21 1904
9. AGE (In years last birthday) 54 — 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) housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Parma Mo. 0
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME David Wilson
14. MOTHER'S MAIDEN NAME Martha Lynn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Nathaniel Lewis Address Parma Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma kidney, liver, intestine
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) metastasis from Ca colon
DUE TO (c) 1538

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 0

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Jan 4, 1958, to May 17, 1958 and last saw her/him alive on May 17, 1958
Death occurred at 2:12 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Dr. Geo. W. Hunter, M.D. (Degree or title)
22b. ADDRESS Parma, Mo.
22c. DATE SIGNED 5/20/58

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE May 20 1958
23c. NAME OF CEMETERY OR CREMATORY City Cemetery
23d. LOCATION (City, town, or county) (State) Malden Missouri

24. FUNERAL DIRECTOR Watkins Funeral Serv. ADDRESS Parma Mo.
25. DATE RECD. BY LOCAL REG. 5/20/58
26. REGISTRAR'S SIGNATURE Dr. Geo. W. Hunter, MD

(Licensed Embalmer's Statement on Reverse Side)

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DATE RECEIVED MAY 27 1958
NEW MADRID CO. HEALTH CENTER
E. S.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Marsh Watkins

Licensed Embalmer No. 471

P. O. Address Dexter M

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