

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030035

FILED VS. AUG 26 1959 278

Primary Registration District No. 3054 Registrar's No. 105

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY PIKE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY PIKE	
b. CITY (If outside corporate limits, give TOWNSHIP only) LOUISIANA		Length of stay in 1b ABOUT 30 Yrs.	
c. FULL NAME OF (If NOT in hospital, give location) LOUISIANA NURSING HOME		c. CITY OR TOWN LOUISIANA	
HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) PLANTERS HOTEL.	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last NELLIE ANN LEWIS		Month Day Year AUG 18 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-11-1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life. (Retired)) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE (last birthday) 90
11. BIRTHPLACE (City and state or country) OKLAHOMA		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME JOHN BAKER.		13b. MOTHER'S MAIDEN NAME MARY BELL ANDERSON	
14. NAME OF HUSBAND OR WIFE TOM LEWIS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Helen Morley	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure - Azotemia		INTERVAL BETWEEN ONSET AND DEATH 1 mo	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular Renal Dis		10 yrs	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 1953 to 8-12-59 and last saw her 8-18-59 alive on 8-18-59		Death occurred at 10:14 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Chas H Lewellen M.D.	22b. ADDRESS Louisiana, Missouri	22c. DATE SIGNED 8-20-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE AUG 21, 1959	23c. NAME OF CEMETERY OR CREMATORY RIVERVIEW CEM	23d. LOCATION (City, town, or county) (State) LOUISIANA MO.
24. FUNERAL DIRECTOR Collier FUNERAL HOME	ADDRESS LOUISIANA MO	25. DATE RECD. BY LOCAL REG. 8-20-59	26. REGISTRAR'S SIGNATURE Bernie Collier

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.