

**FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-036264**

**FILED VS NOV 2 1959**

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5060

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>JACKSON</b>	Length of stay in 1b <b>3 WKS.</b>	a. STATE <b>MISSOURI</b>	b. COUNTY <b>Clay</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		c. CITY OR TOWN <b>NORTH KANSAS CITY</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA HOSPITAL</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1020 EAST 22 ND</b>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print)			<b>4. DATE OF DEATH</b>	
First <b>JEAN</b>	Middle <b>CLIFTON</b>	Last <b>LEWIS</b>	Month <b>October 19</b>	Day <b>1959</b>
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2-24-87</b>	<b>9. AGE</b> (last birthday) <b>72</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Electrician</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Flatte City, Missouri</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
<b>13a. FATHER'S NAME</b> <b>DAN Lewis</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Lizzie PERKINS</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Eva Lewis</b>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WWI</b>		<b>16. SOCIAL SECURITY NO.</b> <b>486-10-5174</b>	<b>17. INFORMANT</b> <b>VA Hospital Official Records, K.C. Mo.</b>	

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
IMMEDIATE CAUSE (a) <b>Pneumonia</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) <b>Hiatal Hernia, esophageal diverticulum</b>	
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

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
<b>21. Attended the deceased from</b> <b>September 29, 1959</b> to <b>October 19, 1959</b>		<b>Death occurred at</b> <b>10:10 p</b> on the date stated above, and to the best of my knowledge, from the causes stated.	

<b>22a. SIGNATURE</b> (Degree or title) <b>Charles E. Andrews, M.D.</b>		<b>22b. ADDRESS</b> <b>VA Hospital, Kansas City, Mo.</b>	<b>22c. DATE SIGNED</b> <b>10-20-59</b>
<b>23a. BURIAL, CREMATION, OR REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE</b> <b>10/21/59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>White Chapel</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>CLAY Co. Mo</b>
<b>24. FUNERAL DIRECTOR</b> <b>D.W. Newcomer's N.C.E.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>10-21-59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Neval Marshall</b>	

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Blair H. Hill

Licensed Embalmer No. 4586

P. O. Address K. C. 18

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.