URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-042146
STATE FILE NUMBER

FILED VS NOV 20 1959

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210149

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.
Length of stay in 1b: 6 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL#1
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1407 Newhouse Avenue
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: OTIS Middle: Last: LEWALLEN
4. DATE OF DEATH Month: NOV. Day: 2 Year: 1959
5. SEX: male
6. COLOR OR RACE: white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2-26-1884
9. AGE (last birthday): 75
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HR: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): High Man - Retired
10b. KIND OF BUSINESS OR INDUSTRY: Patton Scaffold Co
11. BIRTHPLACE (City and state or country): Hannibal, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: James Lewallen
13b. MOTHER'S MAIDEN NAME: Alice Dennison
14. NAME OF HUSBAND OR WIFE: Effie Lewallen
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.: 489-20-7101
17. INFORMANT: Address: Mrs. Marie Riggs, 1405 Newhouse Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Acidosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Pulmonary Insufficiency
DUE TO (c) Chronic Interstitial Pneumonitis
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
1. Congestive Failure 2) ASHD 3) Patch fibrosis of Myocardium

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 525X
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 OCT. 28, 1959, to NOV. 2, 1959 and last saw her/him alive on NOV. 2, 1959
Death occurred at 9:40 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Samuel W. Handy Jr MD
22b. ADDRESS 1515 LAFAYETTE AVE.
22c. DATE SIGNED 10/3/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Nov 6 1959
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County, Missouri

24. FUNERAL DIRECTOR: Math Hermann & Son, Inc., ADDRESS: 2161 E. Fair
25. DATE RECD. BY LOCAL REG.: NOV 5 1959
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. MJC

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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