

**FRI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS FEB 25 1960**

**=60-006941**

Registration District No. 159 Primary Registration District No. 5591 Registrar's No. 110 STATE FILE NUMBER

|   |  |   |  |   |   |  |   |  |  |  |  |                |  |
|---|--|---|--|---|---|--|---|--|--|--|--|----------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>JEFFERSON</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>JEFF.</u>                         |   |  |   |  |  |  |  |                |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>HILLSBORO RT.#1(CENTRAL)</u>  |  | Length of stay in 1b<br><u>50YRS</u>  |  | c. CITY OR TOWN <u>HILLSBORO RT.#1</u>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |  |  |  |  |                |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>5 MI.W.OF DESOTO</u>  |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><u>5MI.W.OF DESOTO</u> |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |  |  |  |                |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>SAMUEL</u> Middle <u>YATES</u> Last <u>LEWIS</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>FEB.</u> Day <u>21</u> Year <u>1960</u>  |   |  |   |  |  |  |  |                |  |
| 5. SEX<br><u>MALE</u>   |  | 6. COLOR OR RACE<br><u>WHITE</u>  |  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>4-9-1881</u>  |   | 9. AGE (last birthday)<br><u>78</u>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.        |  | IF UNDER 24 HR |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FARMER</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>FARM</u>  |   | 11. BIRTHPLACE (City and state or country)<br><u>St. Louis, Mo.</u>                  |   | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>   |  |  |  |                |  |
| 13a. FATHER'S NAME<br><u>DAVID LEWIS</u>  |  |   |  | 13b. MOTHER'S MAIDEN NAME<br><u>KEZIA YATES</u>   |   |  |   | 14. NAME OF HUSBAND OR WIFE<br><u>FLORENCE LEWIS</u>   |  |  |  |                |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>489-42-4165</u>   |   | 17. INFORMANT Address<br><u>FLORENCE LEWIS, HILLSBORO, RT#1</u>                      |   |  |  |  |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO (b) <u>Influenza</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |   |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>7 wks</u> |  |                |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART (a)<br><u>Senile</u>  |  |   |  |   |   |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |  |                |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 <u>1-25-60</u> to <u>1-21-60</u> and last saw her alive on <u>2-19-60</u><br>Death occurred at <u>9.50</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |  |   |   |  |   |  |  |  |  |                |  |
| 22a. SIGNATURE (Degree or title)<br><u>Chas E Faller M.D.</u>   |  |   |  |   |   | 22b. ADDRESS<br><u>Desoto Mo</u>   |   |  |  | 22c. DATE SIGNED<br><u>2-23-60</u>               |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |  | 23b. DATE<br><u>2-24-1960</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>WOODLAWN</u>   |   | 23d. LOCATION (City, town, or county)<br><u>DESOTO, MO.</u>                          |   | (State)  |  |  |  |                |  |
| 24. FUNERAL DIRECTOR<br><u>DIETRICH FUNERAL HOME, DESOTO, MO. 2-23-60</u>   |  |   |  | 25. DATE RECD. BY LOCAL REG.  |   | 26. REGISTRAR'S SIGNATURE<br><u>Clara R. ...</u>                                     |   |  |  |  |  |                |  |

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 Donnell Fred Dietrich, Student Embalmer No. 588

working under my personal supervision.

Student Donnell Fred Dietrich Signed Donnell B Dietrich  
Signature of Student Embalmer

Licensed Embalmer No. 4104

P. O. Address Delto, Mo

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