

MRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-009189

FILED VS MAR 1 0 1960

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 446

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis CLAYTON DOA.</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Enr. St. Louis County Hosp.</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5322 St. Louis Avenue</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Johnnie</u> Middle Last <u>Lewis</u>				4. DATE OF DEATH Month <u>2-</u> Day <u>8-</u> Year <u>60</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5-5-1922</u>	9. AGE (last birthday) <u>37</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>3</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Fred Lewis</u>			13b. MOTHER'S MAIDEN NAME <u>Ella Johnson</u>			14. NAME OF HUSBAND OR WIFE <u>Luella Lewis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes # 2</u>			16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Luella Lewis</u>			Address <u>5322 St. Louis Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>331x</u>									
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 checked="" 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 <u>Aug 9 12 04 30 1957</u> to <u>Feb 7 1960</u> and last saw her/him alive on <u>7th Feb</u> Death occurred at <u>2 30 pm on 8th Feb</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>W. Denton</u> (Degree or title)				22b. ADDRESS <u>2320 Washington</u>			22c. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>2-12-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>		23d. LOCATION (City, town, or county) (State) <u>Edward Mississippi</u>				
24. FUNERAL DIRECTOR <u>Ellis Funeral Home</u> ADDRESS <u>2820 Stoddard</u>				25. DATE RECD. BY LOCAL REG. <u>2-11-60</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 0 T RAVW SA
MAR 1 0 1960

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 Jullon E. Cul
Licensed Embalmer No. 4190

P. O. Address Shaw

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.