

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-023860**

FILED VS. JUL 15 1960

Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 41

STATE FILE NUMBER

UNDEED

1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Miss.</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Charleston</u>		Length of stay in 1b <u>30 min.</u>		c. CITY OR TOWN <u>Deventer</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>en route Doctor's Office</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Gen. Del.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Dennis</u> Last <u>Lewis</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1960</u>	9. AGE (last birthday) <u>---</u>	IF UNDER 1 YEAR Months <u>---</u> Days <u>2</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)			10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (City and state or country) <u>Wyatt, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Walter Lee Lewis</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Alice Lockett</u>			14. NAME OF HUSBAND OR WIFE <u>---</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Walter Lee Lewis, R. 1, Charleston, Mo.</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>Erythroblastosis foetalis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>42 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) _____ 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 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>7/5/60</u> to <u>7/6/60</u> and last saw <del>her</del> him alive on <u>7/5/60</u> Death occurred at <u>5:30</u> P. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>John L. Sparks M.D.</u>				22b. ADDRESS <u>Charleston Mo</u>			22c. DATE SIGNED <u>7/7/60</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/7/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		23d. LOCATION (City, town, or county) <u>Charleston, Mo.</u>				
24. FUNERAL DIRECTOR <u>L.R. Sparks, Charleston, Mo.</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>7-7-60</u>	26. REGISTRAR'S SIGNATURE <u>Dorothy B. Hathorn</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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

This body was not embalmed.

Signed Oliver W. Holme

Licensed Embalmer No. 4190

P. O. Address Charleston

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.