

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-021718

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 163

Primary Registration District No. 5396

Registrar's No. 31

FILED JUN 23 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 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>JEFFERSON</u>                  |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>VALLE</u>   |  | Length of stay in 1b <u>9 MONTHS</u>  |  | c. CITY OR TOWN <u>DE SOTO, Mo., Rt. #2</u>  |  | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BOYD ST. RD. Rt. #2</u>   |  |   |  | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  | d. STREET ADDRESS (If outside, give location) <u>BOYD ST. RD. Rt. #2</u>   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MATTIE SOPHIA LEWIS</u>   |  |   |  | 4. DATE OF DEATH Month Day Year <u>JUNE 19 1961</u>  |  |  |  |
| 5. SEX <u>FEMALE</u>   |  | 6. COLOR OR RACE <u>WHITE</u>   |  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>2/2/1897</u>   |  |
|  |  |   |  | 9. AGE (last birthday) <u>64</u>   |  | IF UNDER 1 YEAR IF UNDER 24 HR<br>Months <u>4</u> Days <u>17</u> Hours <u></u> Min. <u></u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOE WORKER</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>RET. SHOE WORKER</u>  |  | 11. BIRTHPLACE (City and state or country) <u>BELLE, Mo</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u>   |  |   |  |  |  |  |  |
| 13a. FATHER'S NAME <u>AUGUST WITHOUSE</u>  |  |   |  | 13b. MOTHER'S MAIDEN NAME <u>EMMA SCHUSTER</u>   |  | 14. NAME OF HUSBAND OR WIFE <u>MR. JAMES H. LEWIS</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>   |  |   |  | 7. INFORMANT Address <u>MRS. VIRGINIA COLE, ST. LOUIS, Mo.</u>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary thrombosis, with myocardial infarction.</u><br>DUE TO (b) <u></u><br>DUE TO (c) <u></u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>about 10 minutes.</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.<br><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>1955</u> to <u>June 19, 1961</u> and last saw her alive on <u>June 19, 1961</u><br>Death occurred at <u>7:50 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |  |  |  |  |  |
| 22a. SIGNATURE (Degree or title) <u>Thomas A. Donnell M.D.</u>   |  |   |  | 22b. ADDRESS <u>De Soto, Mo.</u>   |  | 22c. DATE SIGNED <u>6-19-61</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 23b. DATE <u>6/21/61</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>  |  | 23d. LOCATION (City, town, or county) (State) <u>FRANKLIN COUNTY, Mo.</u>  |  |
| 24. FUNERAL DIRECTOR ADDRESS <u>DIETRICH F. HONE, DE SOTO, Mo.</u>   |  |   |  | 25. DATE RECD. BY LOCAL REG. <u>6-20-1961</u>  |  | 26. REGISTRAR'S SIGNATURE <u>Marie Harris</u>  |  |

JUN 23 1961

**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 Donell B. Dietz

Licensed Embalmer No. 4104

P. O. Address Deerfield, Mo.

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.