

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047508

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 252

STATE FILE NUMBER

AMENDED

FILED JAN 2 1962

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| 1. PLACE OF DEATH a. COUNTY <u>SCOTT</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>SCOTT</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SIKESTON</u> | | c. CITY OR TOWN <u>SIKESTON</u> | |
| Length of stay in 1b | | 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>SHUFFIT NURS. HOME</u> | | d. STREET ADDRESS (If outside, give location) <u>219 E. KATHLEEN</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA TIERY LEWIS</u> | | | 4. DATE OF DEATH Month Day Year <u>12-27-61</u> | | |
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| 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>3-14-1877</u> | 9. AGE (last birthday) <u>84</u> | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--------------------------------|------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>DAWSON SPRINGS KY.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>SAMUEL JACKSON TIERY</u> | 13b. MOTHER'S MAIDEN NAME <u>MARTHA PURDY</u> | 14. NAME OF HUSBAND OR WIFE <u>WM. ZEPH LEWIS</u> |
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| 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>NONE</u> | 17. INFORMANT Address <u>Wm. R. Lewis - Sikeston Mo</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> | | |
| DUE TO (b) <u>generalized arteriosclerosis</u> | | |
| DUE TO (c) _____ | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>fracture left leg</u> | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED? 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.) |
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| 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 |
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| 21. I attended the deceased from <u>April 1951</u> to <u>12/27/61</u> and last saw ^{her} / _{him} alive on <u>12/27/61</u> Death occurred at <u>8:15 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) <u>Wm. C. Cutchlow M.D.</u> | 22b. ADDRESS <u>Sikeston Mo</u> | 22c. DATE SIGNED <u>12/28/61</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>12-29-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u> | 23d. LOCATION (City, town, or county) (State) <u>SIKESTON Mo</u> |
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| 24. FUNERAL DIRECTOR ADDRESS <u>Welch Funeral Home - Sikeston Mo</u> | 25. DATE RECD. BY LOCAL REG. <u>12-28-1961</u> | 26. REGISTRAR'S SIGNATURE <u>Jeanette Waldman</u> |
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Raymond Lewis

Permit issued

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.