

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

31950
Do not use this space.

1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 85
 (b) Township 1 Primary Registration District No. 1007
 (c) City St. Joseph (d) Street No. STATE HOSPITAL #2 Registered No. 1001
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 12 yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME William Wade Lewis
 (a) Residence, No. 2918 Osage St., Wash. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 19, 1904

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
34 9 12

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Labr
 9. Industry or business in which work was done, as saw mill, bank, etc. Boating House
 10. Date deceased last worked at this occupation (month and year) Dec. 31, 1938 11. Total time (years) spent in this occupation 4 1/2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bentley Co., Mo.

FATHER
 13. NAME W. H. Lewis 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER
 15. MAIDEN NAME Harris Good 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Prof. Records.

18. BURIAL, CREMATION, OR REMOVAL Union Chapel Cem DATE Oct 3 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ray Slawson
24 Maple St. Wash.

20. FILED Oct 7 39 W. J. Westlund
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 1, 1939

22. I HEREBY CERTIFY, That I attended deceased from 9/18/39, 1939, to 10/1/39, 1939.
 I last saw him alive on Oct. 1, 1939. Death is said to have occurred on the date stated above, at 1:15 P.M.
 The principal cause of death and related causes of importance were as follows:
shin, abrasion done to
achilles tendon (Achilles tendon)
achilles tendon of right leg
fractured
 Date of onset 2/1/39
2/1/39

Other contributory causes of importance: 4 3 0

Name of operation..... Date of.....
 What test confirmed diagnosis? History Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury..... 1 don't know

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify.....
 (Signed) G. N. Panethiere M. D.
 (Address) State Hospital No 2

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.....

John H. Hurley
.....
working under my personal supervision.

Registered Apprentice No.

Signed *John H. Hurley*
.....

Licensed Embalmer No. *4050*

P. O. Address *2335 St Joseph Ave*

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 this body is not embalmed, above space should be left blank.