

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7351

State File No.

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 79

1. PLACE OF DEATH:

(a) County Marion
 (b) City or town Hannibal
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution St Elizabeth Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1
 (Specify whether
 In this community
 years, months or days)

3. (a) PRINT FULL NAME Edith Jewis 2nd

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Frank Jewis 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept 29 1884
 (Month) (Day) (Year)

8. AGE: Years 55 Months 4 Days 19 If less than one day hr. _____ min. _____

9. Birthplace Mo (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business

MOTHER FATHER
 12. Name Wm Ford
 13. Birthplace Mo (City, town, or county) (State or foreign country)
 14. Maiden name Glynn Ford
 15. Birthplace Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank Jewis
 (b) Address 2011 Garden St
 17. (a) Burial (b) Date thereof 2-21-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Robinson home
 18. (a) Signature of funeral director Geo E Roberts
 (b) Address Hannibal Mo
 19. (a) 2-28-40 (b) Th E Fisher
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion
 (c) City or town Hannibal
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2011 Garden St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18
 year 1940 hour 3 minute 50 M.

21. I hereby certify that I attended the deceased from 2/9/40 19____; 2/18/40 19____;
 that I last saw her alive on 2/18/40 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia
 Due to Influenza
 Due to _____

Other conditions (include pregnancy within 3 months of death) _____
 Major findings: HN
 Of operations _____
 Of autopsy _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? Yes
 While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature H. D. M. Weeks (M. D. or other) _____
 Address Hannibal Mo Date signed _____

AUG 7 1948

JUN 9 1950

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7357**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Oregon**
(b) City or town **Hannibal**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **Edith Lewis**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **7** 5. Color or race **col** 6. (a) Single, widowed, married divorced **married**
6. (b) Name of husband or wife **Frank F. Lewis** 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **55** Months **4** Days **19** If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **March 11, 1940** (b) **Edith Lewis**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MENTAL CERTIFICATION

20. DATE OF DEATH: month **Feb** day **18**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that last saw h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **H. B. McMecham** D. or other) _____

Address **Hannibal** _____ signed.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

