

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-043034

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 1898

FILED NOV 26 1963

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>IRON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>POPLAR BLUFF</b>		c. CITY OR TOWN <b>GLOVER</b>	
Length of stay in 1b <b>8 DAYS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <b>VA HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>ROUTE #1, BOX 65</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>TONEY LEE LEWIS</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>18</b> Year <b>1963</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-14-90</b>
9. AGE (last birthday) <b>73</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (City and state or country) <b>SABULA, MISSOURI</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>ROBINSON LEWIS</b>	
13b. MOTHER'S MAIDEN NAME <b>MARTHA JANE NANCE</b>		14. NAME OF HUSBAND OR WIFE <b>NANNIE LEWIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>UNK</b>	
17. INFORMANT <b>VA HOSPITAL RECORDS, POPLAR BLUFF, MO.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (c) <b>CONGESTIVE HEART FAILURE</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>CONGESTIVE HEART FAILURE</b>		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 <b>5:00</b> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.) <b>VA</b>	
20f. CITY, TOWN, OR LOCATION <b>VA</b>		COUNTY <b>IRON</b> STATE <b>MISSOURI</b>	
21. I attended the deceased from <b>11-10-63</b> to <b>11-18-63</b> and last saw him alive on <b>11-18-63</b> Death occurred at <b>5:00 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>R. S. COHEN, M.D., Chief, Medical Service VA Hospital, Poplar Bluff, Mo.</b>	
22b. ADDRESS <b>VA Hospital, Poplar Bluff, Mo.</b>		22c. DATE SIGNED <b>11-19-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>11/21/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Big Creek Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Glover, Missouri</b>
24. FUNERAL DIRECTOR <b>White Funeral Home, Ironton, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-21-1963</b>	
26. REGISTRAR'S SIGNATURE <b>Thelma Graham</b>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300  
Rev. 4/59  
1 0128  
2 0496  
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DATE AMENDED