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

1. PLACE OF DEATH
County Madison · Registration District No. 538 · File No. 1525
Township Castor — Primary Registration District No. 5727 · Registered No. 4
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Elizabeth Lewis

(a) Residence. No. ..... St. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Lee Lewis

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
	30	11	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Shelby Co. Mo

PARENTS
10. NAME OF FATHER Louis Blight
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ill
12. MAIDEN NAME OF MOTHER Mary Peak
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Shelby Co Mo.

14. INFORMANT Lee Lewis
(Address) Bonneville Mo

15. FILED Feb 6, 1923 Wm Nelson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 16 1923

17. I HEREBY CERTIFY, That I attended deceased from Jan 13, 1923 to Jan 16, 1923 that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 7:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza & Pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) C. M. Davis, M. D
, 19 (Address) Fayette Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Shannville	Jan. 17 1923
20. UNDERTAKER None	ADDRESS

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.

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. See instructions on back of certificate.

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

538
5727

1 PLACE OF DEATH

County Madison

Township Paxton
or
Village
or
City (No. , St.; Ward)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State of

Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Elizabeth Lewis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): M

6 DATE OF BIRTH: X Jan (Month) 16 (Day) 1893 (Year)

7 AGE: Years 30 Mos. 1 Ds. — If LESS than 1 day, hrs. or min.

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed Feb 23, 1923 W Nifong
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 16 (Day) 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from , 191, to , 191, that I last saw h alive on , 191, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) , M. D.

, 191 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL , 191

20 UNDERTAKER | ADDRESS

11—3184