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

File No. 13277

1 PLACE OF DEATH

County Gasconade

Township Liberty

or

Village —

or

City —

Registration District No. 113

Primary Registration District No. 5763

Registered No. 6

(NO. ..... St. ..... Ward)

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

2 FULL NAME William Lee

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

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

6 DATE OF BIRTH: Unknown (Month) ..... (Day) 1 — (Year)

7 AGE: about 50 yrs. — mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS

10 NAME OF FATHER: William Lee

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Unknown

12 MAIDEN NAME OF MOTHER: Nerinit Lee

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Effie Lee

(Address) Auxvasse Mo.

15 Filed April 25th, 1915. Wm B Ellis, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 24th (Day), 1915 (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 27th, 1915, to April 28th, 1915, that I last saw him alive on April 23th, 1915, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm B Ellis M. D.

..... 191..... (Address) Auxvasse Mo

*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: Pleasant Hill Cem.

DATE OF BURIAL: April 25, 1915

20 UNDERTAKER: Murphin & Co

ADDRESS: Auxvasse Mo

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ..... St. ..... Ward)

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

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH ..... (Month) ..... (Day) ..... 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ..... 191..... ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH ..... (Month) ..... (Day) ..... 191..... (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

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

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