

Not properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH

County Andrew
Township Lincoln
or
Village Amazonia
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 8 File No. 27
Primary Registration District No. 4005- Registered No. _____

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

FULL NAME

Charley Emerson Lee

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE ✓ SINGLE MARRIED WIDOWED OR DIVORCED (write the word)
DATE OF BIRTH September 23, 1872
(Month) (Day) (Year)
AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?
yrs. 4 mos. 4 ds.

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

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

PARENTS
NAME OF FATHER Chas. Lee
BIRTHPLACE OF FATHER Missouri
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Ma Kellie
BIRTHPLACE OF MOTHER Missouri
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. C. Lee
(ADDRESS) Amazonia Mo

Filed 22, 1923, J. W. Holcomb
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 21, 1923
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 15th, 1923, to Jan 20, 1923, that I last saw him alive on Jan 20, 1923, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:
Pneumonia Bronchial
107 A a

(Duration) _____ yrs. _____ mos. 24 ds.

Contributory 10
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) S. S. Owen M. D.
Jan 22, 1923 (Address) Amazonia

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. 1 mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Amazonia Mo DATE OF BURIAL Jan 22, 1923

UNDERTAKER. _____ ADDRESS Amazonia Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



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

1. PLACE OF DEATH

County Andrew Registration District No. 8 File No. _____
 Township _____ Primary Registration District No. 4005 Registered No. _____
 City Amazonia (No. _____) St. _____ Ward _____

2. FULL NAME

Charley Emmerson Lee
 (a) Residence No. _____ St. _____ Ward _____ (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 23, 1922

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
4 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED 1-22-1923 J. W. Holcomb REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 21 1923

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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) _____, M. D.
 _____, 19 (Address)

*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

Amazonia Cemetery 19
 ADDRESS

20. UNDERTAKER

ADDRESS

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.....)..... St..... Ward.....

2. FULL NAME

(a) Residence. No..... Ward.....
 (Usual place of abode).....
 Length of residence in city or town where death occurred yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

[Handwritten initials]

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

YEARS	MONTHS	DAYS	IF LESS THAN 1 day,hrs. ormin.
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8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work.....
 (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).....

10. NAME OF FATHER.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY).....

12. MAIDEN NAME OF MOTHER.....

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY).....

14. INFORMANT (Address).....

15. FILED....., 19....., REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)..... 19.....

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at....., Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
 (duration)..... yrs. mos. ds.
 (duration)..... yrs. mos. ds.
 (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED.....

IF NOT AT PLACE OF DEATH..... DATE OF.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.
 , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MANNER 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.....

20. UNDERTAKER..... ADDRESS.....