

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

Do not use this space.

~~80657~~  
~~30239~~

**1. PLACE OF DEATH**  
 County Jackson Registration District No. 400  
 Township De Prairie Primary Registration District No. 5553 B.  
 City Longview Farm St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** James Anderson Lee  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

File No. 30239  
 Registered No. 111  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**PERSONAL AND STATISTICAL PARTICULARS**

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

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** \_\_\_\_\_

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Feb 26 - 1927

**7. AGE** YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
7 18

**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work Infant.  
 (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)** Longview Farm Mo.

**10. NAME OF FATHER** Parker Lee

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

**12. MAIDEN NAME OF MOTHER** Ora Marion

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

**14. INFORMANT (Address)** Halyn Lee Longview Farm

**15. FILED** Oct 19 27 F. M. Schick  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Oct 15 - 1927.

**17. I HEREBY CERTIFY**, That I attended deceased from Oct 12 1927 to Oct 15 1927  
 that I last saw deceased alive on Oct 15 1927, and that death occurred, on the date stated above, at 5:20 am

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
Influenza & Influenza

11/3 / 11/3 (duration) yrs. mos. 2 ds.

**CONTRIBUTORY (SECONDARY)** none  
 (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH? same

**DID AN OPERATION PRECEDE DEATH?** no DATE OF \_\_\_\_\_

**WAS THERE AN AUTOPSY?** no

**WHAT TEST CONFIRMED DIAGNOSIS?** Symptoms  
 (Signed) J. J. Gale, M. D.  
 , 19 Oct 15 1927 Address Longview Farm 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.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Mulberry Kansas **DATE OF BURIAL** Oct 16 19 27

**20. UNDERTAKER (Address)** T. J. Schick & Son

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.

NOV 26 1927

