

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

Do not use this space.

24727

1. PLACE OF DEATH

County *Phelps*
Township *St. James*
City *St. James* (No.)

Registration District No. *678*
Primary Registration District No. *4404*

File No.
Registered No.
St. Ward)

2. FULL NAME

Mary Ellen Lee

(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred *58* yrs. *4* mos. *27* ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb. 14th 1869*

7. AGE YEARS *58* MONTHS *4* DAYS *27* If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Home wife*
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. James Mo.*
(STATE OR COUNTRY)

10. NAME OF FATHER *John Kahoe*

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

12. MAIDEN NAME OF MOTHER *Not known*

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

14. INFORMANT *Mrs. Margueth Masling*
(Address) *Cuba Mo.*

15. FILED *7/13* 19*28* *Sherry F. Walters* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 11th 1928*

17. I HEREBY CERTIFY That I attended deceased from *July 11th 1928* to *July 11th 1928* that I last saw *her* alive on *July 11th 1928*, and that death occurred, on the date stated above, at *4:35* p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic interstitial nephritis

121 (duration) *1* yrs. *1* mos. *1* ds.

CONTRIBUTORY (SECONDARY)

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

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF *7/13/28*
WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *William H. Green*, M. D.
7/13/28 (Address) *St. James 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 *Catholic Cemetery* DATE OF BURIAL *July 13th 1928*

20. UNDERTAKER *Jonas and Ten Eyck* ADDRESS *St. James Mo.*

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.

59-4-8

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Phelps Registration District No. 678 File No.
 Township St. James Primary Registration District No. 4404 Registered No.
 City St. James (No.) St. Ward

2. FULL NAME Mary Ellen Lee

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 14 - 1869

7. AGE YEARS MONTHS DAYS If LESS than day, hrs. or min.
59 * 4 27

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 7/13 19 28 Henry B. Walters REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 11 1928

17. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to, 19....., 19....., and that (that I last saw h..... alive on, 19....., and that death occurred, on the date stated above, at

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

N. B.— item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
 REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 ANS should state is very important.

SUPPLEMENTARY

