

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

Do not use this space.

38149

1. PLACE OF DEATH

County St. Louis Registration District No. 1170
 Township Richmond Primary Registration District No. 6248 H
 City Richmond, Mo. (No. St. Mary's Hospital) St. _____ Ward _____

File No. _____
 Registered No. 267
 St. _____ Ward _____

2. FULL NAME Bassom Lee

(a) Residence. No. Greenville, Mo. 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May, 10, 1866

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
62 6 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming
 (b) General nature of industry, business, or establishment in which employed (or employer) His Own
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Missouri
 (STATE OR COUNTRY)

10. NAME OF FATHER Wm Lee

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT E. R. Smith
 (Address) 4061a DeTonty St.

15. FILED 11/25, 1928 C. L. Jensen
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 25 19 28

I HEREBY CERTIFY That I attended deceased from Nov 13, 1928 to Nov 25, 1928
 that I last saw h. born alive on Nov 24, 1928, and that death occurred, on the date stated above, at 6.30 a. A.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myeloid Leukemia
72A
102A 65 W (duration) 6 yrs. 6 mos. — ds.
 CONTRIBUTORY acute bronchitis
 (SECONDARY) (duration) 1 yrs. 1 mos. — ds.

18. WHERE WAS DISEASE CONTRACTED Greenville Mo
 IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Blood Et-

(Signed) C. H. Stephens, M. D.

, 19 (Address) 312 Lister Bldg

*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

Greenville, Mo. Nov. 28th 28

20. UNDERTAKER A. W. M. Langdon
 ADDRESS 1631 Mo. Ave

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.

WHILE PRINTING, WITH UNFOLDING INK—THIS IS A PERMANENT RECORD

