

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

Do not use this space.

8.1929

1. PLACE OF DEATH

County St. Louis
Township
City Richmond Heights Mo.

Registration District No. 1170
Primary Registration District No. 6248H
City Richmond Heights, Mo.

File No. 19402
Registered No. 1285
St. _____ Ward _____

2. FULL NAME Dorothy Lee

(a) Residence. No. Hanley Rd. St. _____ Ward _____
(Usual place of abode)
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 Female 4. COLOR OR RACE Negro 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) June 30, 1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
10 10

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER Clarence Lee
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Vicksburg
(STATE OR COUNTRY) Mississippi
12. MAIDEN NAME OF MOTHER Lillian Lee
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Mississippi

14. INFORMANT Lillian Lee
(Address) Richmond Heights, Mo.

15. FILED 5/13 1929 E. L. Jensen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 10th 1929
17. I HEREBY CERTIFY, That I attended deceased from May 8th 1929 to May 10th 1929 that I last saw him alive on May 10th 1929 and that death occurred, on the date stated above, at 6:15 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza
broncho pneumonia
HA
107H (duration) yrs. mos. ds.
CONTRIBUTORY Broncho pneumonia (SECONDARY) (duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED Richmond Heights
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) E. V. Roberts M. D.
, 19 (Address) 2111 97 market

*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 Father Dickson Cemetery DATE OF BURIAL 5-13-29

20. UNDERTAKER Gates Funeral Home ADDRESS 4104 Murray

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

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.

