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

Do not use this space.

33898

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No. 4351

Township Kaw — Primary Registration District No. 1002 — Registered No.

City Kansas City (No. Kansas City Genl Hosp St. Ward)

2. FULL NAME Charles H. Lee

(a) Residence. No. Jackson W. Home St. Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 18 - 1854

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	75	3	2	

8. OCCUPATION OF DECEASED

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

(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) Ohio

PARENTS

10. NAME OF FATHER James Lee

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

12. MAIDEN NAME OF MOTHER Jane Wright

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

14. INFORMANT Reuna Clerk (Address) K.C. Genl Hosp

15. FILED 10/21/1929 M. M. Crowe asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-20 1929

17. I HEREBY CERTIFY, That I attended deceased from 10-8, 1929 to 10-20, 1929 that I last saw him alive on 10-20, 1929, and that death occurred, on the date stated above, at 10:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypertrophy of Prostate

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133C (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Hydronephrosis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) P. E. Williams, M. D.

10-20, 1929 (Address) Supt K.C. Genl Hosp

*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
Leeds	10/22 1929

20. UNDERTAKER	ADDRESS
O. P. Mast	1915 East 15

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.

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

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