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

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.

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

Do not use this space.

35459

1. PLACE OF DEATH

County ..... Registration District No. 791 1003

Township ..... Primary Registration District No. .....

City St Louis Mo (No. City Hospital ..... St. ..... Ward)

File No. .....

Registered No. 10205

2. FULL NAME Lee Margell

(a) Residence. No. 4239 Olive St., 19 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 OF: Louise Margell

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 16

7. AGE: About 48 Years (YEARS / MONTHS / DAYS) If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Furniture Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

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9. BIRTHPLACE (CITY OR TOWN): Not Known
(STATE OR COUNTRY): Russia

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PARENTS

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (CITY OR TOWN): Not Known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Not Known
(STATE OR COUNTRY)

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14. INFORMANT: Louise Margell
(Address): 4468 Page Blvd

15. FILED OCT 18 1929 19 Max C. Tomelly REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct. 15 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 9.55 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Haemorrhage of Bra
204M
82A
Fractured Skull
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Struck by Street Car
No Auto (duration) yrs. mos. ds.
Accident

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

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kerner, M.D.

10/17 1929 (Address) Dep. Coroner

*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: Memorial Park

DATE OF BURIAL: Oct 18 1929

20. UNDERTAKER: Kendler Hud Co

ADDRESS: 7819 Mich Av

MAY 11 1954