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

Do not use this space.

8943

File No. 8943
Registered No. 8943

1. PLACE OF DEATH
County: Jackson Registration District No.: 2 0 6
Township: Kansas City Primary Registration District No.:
City: (Not in City or Town) General Hospital #2 St. Ward)

2. FULL NAME: Lee, Willie
(a) Residence. No. 1500 Paseo St., 4 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	Col	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 1880

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
49			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Corn Laborer
(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) Arkansas

PARENTS
10. NAME OF FATHER Milton Lee
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Arkansas
12. MAIDEN NAME OF MOTHER Anna
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mississippi

14. INFORMANT: Record Clerk
(Address) General Hospital #2

15. FILED 3/25, 19 30 M. M. Crowe
REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-21 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-18 1930, 1930 to 3-21, 1930 that I last saw him alive on 3-21-30, 1930 and that death occurred, on the date stated above, at 6:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
Myocarditis
102
93D
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 101 A
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Unknown
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
3/22 1930 (Signed) J. W. Smith, M. D.
(Address) General Hospital #2

*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
Fordyce, Ark	Mar 25 1930
20. UNDERTAKER	ADDRESS
Mattson Bros	1729 Lydia

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.