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

Do not use this space.

12833

1. PLACE OF DEATH

County: Jackson — Registration District No.: 38 — File No.: 1132

Township: Raw — Primary Registration District No.: 10 — Registered No.: 1132

City: Kansas City (No.) General Hosp. # 2 St. (Ward)

2. FULL NAME: John Lee

(a) Residence. No. 1119 E 17 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: Male — 4. COLOR OR RACE: Cr — 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 25 1885

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
44	5	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Miss
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER: C J Lee

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

12. MAIDEN NAME OF MOTHER: Unknown

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

14. INFORMANT: Sadie Lee
(Address): 1119 E 17 St

15. FILED 4/22 19 30 M. M. Crowe Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 4-19-30

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to 4-19-30, 19..., that I last saw h. m. alive on 4-19-30, 19..., and that death occurred, on the date stated above, at 11:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
131
93c
mitefunte (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Nephritis, Chronic
Don't Know (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H M Smith, M. D.
4/ 19 30 (Address) City Hosp # 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: Highland Cem. — DATE OF BURIAL: 4-23 1930

20. UNDERTAKER: H B Moore — ADDRESS: 1820 E 18

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