

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

Do not use this space.

*Dr. J. L. ...*  
File No. **23758**  
Registered No. **91**  
St. \_\_\_\_\_ Ward)

**1. PLACE OF DEATH**

County *Jefferson* Registration District No. **681**  
Township *Little Prairie* Primary Registration District No. **3862**  
City \_\_\_\_\_ (No. \_\_\_\_\_) \_\_\_\_\_ St. \_\_\_\_\_ Ward)

**2. FULL NAME**

*Easter, Lee*  
(a) Residence. No. \_\_\_\_\_ St., \_\_\_\_\_ 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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX <i>Female</i>	4. COLOR OR RACE <i>Black</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <i>Single</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>DK</i>				
7. AGE <i>About 11</i>	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer				

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-13-30*

17. I HEREBY CERTIFY, That I attended deceased from *7-12-30* to *5-15-30*, 19*30*, that I last saw *her* alive on *2-15-30*, 19*30*, and that death occurred on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
*Sport swimming*

*108*  
(duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) *1010*  
(duration) yrs. mos. ds.

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER *111*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *111*  
(STATE OR COUNTRY)

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

19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) *J. Bluten*, M. D.  
*7/31-1930* (Address) *Caruthersville*

\*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.

14. INFORMANT *Ed Harrison*  
(Address) *Caruthersville*

15. FILED *July 31 1930* *Ada Martin*  
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Morgan Ridge Cemetery* DATE OF BURIAL *7-14-30*

20. UNDERTAKER *H. Smith* ADDRESS *Caruthersville*

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 very important.

*6-19-30*

