

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

Do not use this space.

29 *Dr. Busick
Medical*

OCT 28 1930

File No. _____
Registered No. 737
St. _____ Ward _____

1. PLACE OF DEATH
County Greene Registration District No. 218
Township _____ Primary Registration District No. 2001
City Springfield (No. 620 St. Louis St.) St. _____ Ward _____

2. FULL NAME John Lawrence Lee Jr
(a) Residence, No. 620 St. Louis 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

3. SEX m 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) mech 6 1926

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
4 6 22

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

9. BIRTHPLACE (CITY OR TOWN) Springfield, Missouri
(STATE OR COUNTRY)

10. NAME OF FATHER Lawrence Lee

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

12. MAIDEN NAME OF MOTHER Christine Schaeffer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Springfield, Mo
(STATE OR COUNTRY)

14. INFORMANT J. Lawrence Lee
(Address) Springfield Mo

15. FILED 9-29-30 Em Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 28 - 1930

17. I HEREBY CERTIFY, That I attended deceased from 9-27-30, 1930, to 9-29-30, 1930
that I last saw him alive on 9-29- 1930 and that death occurred, on the date stated above, at 7:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Polio encephalitis
16 (duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) 22 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS spinal fluid exam
(Signed) Urban Busick M. D.
(Address) Springfield, Mo

*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 Maple Park DATE OF BURIAL Sept 29 1930

20. UNDERTAKER Anna Rosemary F. N. ADDRESS 534 St Louis

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.

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