

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

Do not use this space.

29-2519

1. PLACE OF DEATH
 7² County Newton Registration District No. 414
 Township Marion Primary Registration District No. 5-814
 City..... (No. St. Ward)

File No.
 Registered No. 5

2. FULL NAME Bettie Nell 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

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
 5 18
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. none
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.

MEDICAL CERTIFICATE OF DEATH

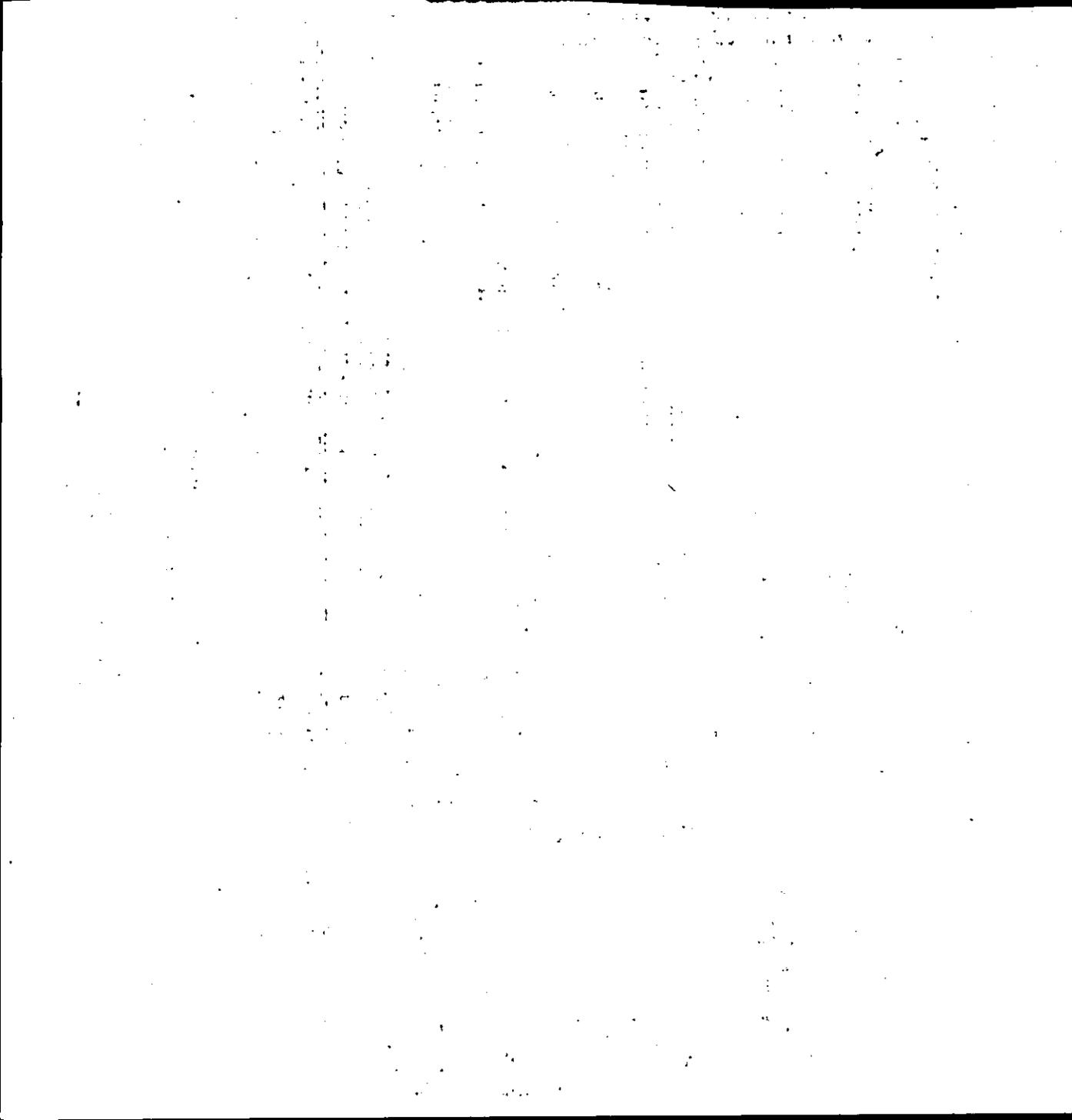
21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-11-1933
 22. I HEREBY CERTIFY, That I attended deceased from July 29, 1933, to June 11, 1933
 I last saw her alive on July 1, 1933 Death is said to have occurred on the date stated above, at 9 a. m.
 The principal cause of death and related causes of importance were as follows:

Spinal Bifida

Date of onset
157 / 57 B
 Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Newton, Mo.
 13. NAME Clara Lee
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Newton, Mo.
 15. MAIDEN NAME Cecil Fay Cameron
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Newton, Mo.
 17. INFORMANT Mrs. Chas. Ritter
 (ADDRESS)
 18. BURIAL, CREMATION, OR REMOVAL
 PLACE Greenwood DATE Jan 12 1933
 19. UNDERTAKER Mrs. Ritter
 (ADDRESS)
 20. FILED 1-11-1933 Dr. W. F. Palmer
 Registrar.

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury.....
 Nature of injury.....
 24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify Spinal Bifida
 (Signed) , M. D.
 (Address) Marion, Mo.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Newton
Township Granby
City _____ (No. _____) St. _____ Ward _____

Registration District No. 614
Primary Registration District No. 3816

File No. 23 -
Registered No. 6

2. FULL NAME

Bettie Nell 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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W (use the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 24 1899

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
5 18

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19__

19. UNDERTAKER (ADDRESS)

20. FILED 1-11-1933 Dr. J. F. Palmer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 11 1933

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) _____, M. D.

(Address) _____

SUPPLEMENTARY

S-2519