

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.

REC'D SEP 13 1938

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

27898
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 100 Registered No. 3209
 (c) City Kansas City, Mo. (d) Street No. General Hospital #2 St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Silas Lee
 (a) Residence, No. 1130 E. 24th St. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF none

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-23-1888

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
1	50	5	17	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. unemployed

9. Industry or business in which work was done, as 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) Don't know

FATHER

13. NAME Don't know

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

MOTHER

15. MAIDEN NAME Don't know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT (ADDRESS) General Hosp. #2

18. BURIAL, CREMATION, OR REMOVAL PLACE Final Cen. DATE 8-12-38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) West Appleton
1925 1/2 ind. st.

20. FILED Aug 12 '38 M. M. Crows
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 10 1938

22. I HEREBY CERTIFY, That I attended deceased from 7-14, 1938 to 8-10, 1938
 I last saw him alive on 8-10, 1938 Death is said to have occurred on the date stated above, at 10:30 am.
 The principal cause of death and related causes of importance were as follows:
Cholelithiasis
(Operated) gall
 Date of onset _____

Other contributory causes of importance:
Acute Coronary Occlusion

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

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) S. O. Brown, M. D.
 (Address) 600 E. 2nd St.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No. *2710*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.