

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

35010
Do not use this space.

REC'D NOV 15 1938

1. PLACE OF DEATH
 (a) County Wagoner Registration District No. 34
 (b) Township Wagoner Primary Registration District No. 6239 Registered No. 23
 (c) City Wagoner, Mo. (d) Street No. _____ 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 Elizabeth Lee
 (a) Residence, No. Cassville, Mo. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charles M Lee

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 6 1849

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>88</u>	<u>10</u>	<u>12</u>	

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

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) Same 1

FATHER

13. NAME Martin Brown 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) OK 9

MOTHER

15. MAIDEN NAME OK

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

17. INFORMANT Miss M Lee
 (ADDRESS) Nauvoo City Mo 1420

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Cassville DATE Sept 20 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Home - Cassville

20. FILED Oct. 31, 1938 Mrs. H. O. Seary
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 18 1938

22. I HEREBY CERTIFY, that I attended deceased from Sept 15 1938, to Sept 18 1938
 I last saw him alive on Sept 18 1938 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:
Cardiac Decompensation Date of onset Sept 15 1938
Chronic Bronchitis
Nephritis
not determined } 121

Other contributory causes of importance:
Chronic Bronchitis emb.
Nephritis

Name of operation _____ Date of _____
 What test confirmed diagnosis? Cholesterol 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.

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Robert Newman M. D.
Cassville, Mo. (Address)

STATEMENT BY LICENSED EMBALMER
CONTAINING INFORMATION CONCERNING
THE DEATH OF THE DECEASED

RECEIVED

District Health Officer No. 8,

District File Number 6-38-460

Date Filed 11/4/38

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,

G. E. Colver

or by

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

Signed

G. E. Colver

Licensed Embalmer No.

3584

P. O. Address

Cassville Mo

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.