

FILED MAY 17 1940

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

15659

PLACE OF DEATH

County *Wayne*
Township *Jefferson*
City (No. *500*)

Registration District No. *643*
Primary Registration District No. *5952*

File No.
Registered No.
St. Ward

2. FULL NAME

Henry August Lee
(a) Residence. No. St. Ward
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Almeda Lee*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 3 - 1865*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 7 0

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Gasconade Co Mo*

10. NAME OF FATHER *Wm Lee*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Don't know*

12. MAIDEN NAME OF MOTHER *Nadora Smith*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Don't know*

14. INFORMANT (Address) *Ray Lee Bland Mo*

15. FILED *May 19 40* *Wm Howard Johnson* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *2-3 1940*

I HEREBY CERTIFY, That I attended deceased from *Jan 28 1940* to *2-3 1940* that I last saw him alive on *2-3 1940* and that death occurred, on the date stated above, at *4 P. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia

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

18. WHERE WAS DISEASE CONTRACTED (IF NOT AT PLACE OF DEATH) *108*

DID AN OPERATION PRECEDE DEATH? DATE OF

19. WAS THERE AN AUTOPSY? WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *Ed Bunge* M. D.
, 19 (Address) *Bland 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 DATE OF BURIAL
Union Cem Bland 2-6 1940

20. UNDERTAKER ADDRESS
G. H. Licklider Belle Mo

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

477

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

1. PLACE OF DEATH

County..... Registration District No.....
 Township..... Primary Registration District No.....
 City..... (No.....)

File No.....
 Regis.....

2. FULL NAME

(a) Residence. No..... St..... Ward.....
 (Usual place of abode) (If nonresident,
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth

PERSONAL AND STATISTICAL PARTICULARS

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

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. 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.....

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

10. NAME OF FATHER.....

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

12. MAIDEN NAME OF MOTHER.....

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

14. INFORMANT..... (Address).....

15. FILED....., 19..... REGISTRAR

MEDICAL CERTIFICATE

16. DATE OF DEATH (MONTH, DAY AND YEAR).....

17. I HEREBY CERTIFY, That I attended....., 19....., to.....

that I last saw h..... alive on..... death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS.....

CONTRIBUTORY (SECONDARY)..... (duration).....

18. WHERE WAS DISEASE CONTRACTED.....

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19..... (Address).....

*State the DISEASE CAUSING DEATH, or in detail (1) MEANS AND NATURE OF INJURY, and (2) Whether HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL.....

20. UNDERTAKER.....

PARENTS

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 DEPARTMENT OF HEALTH
 COLUMBIA, MISSOURI

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 15-659

Registration District No. 643

Primary Registration District No. 5822

Registrar's No.

1. PLACE OF DEATH:

(a) County Asasage
(b) City or town Jefferson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Gasconade
(c) City or town Near Bland Mo Co
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME Henry August Ree

3. (b) If veteran, name war _____ 3. Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 74 Months 7 Days 0 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) June 11 1940 (b) Two General Johnson
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 3
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature C. A. Bunge (M. D. or other) _____
Address Bland, Mo Date signed _____

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
ROWENA

