

293
 No. 2
 11-10-39
 5-17-39
 I-X21492
 FILED

Registration District No. **791** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 Days
(Specify whether life years, months or days)

3. (a) PRINT FULL NAME William Lee
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Male **5. Color or race** White
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased September 30 1939
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	7	2	_____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____
12. Name William Lee
13. Birthplace Chicago Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Rose Ann Boswell
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant William E. Lee
(b) Address 610 Marion st.

17. (a) Burial St. Hope Cemetery
(Burial, cremation, or removal) **(b) Date thereof** May 3 1940
(Month) (Day) (Year)

18. (a) Signature of funeral director [Signature]
(b) Address 7814 S. Broadway

19. (a) MAY 3 1940 **(b) [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town St. Louis 23
(If outside city or town limits, write "RURAL")
 (d) Street No. 610 Marion ave.
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 2
 year 1940 hour 5 minute 10 A. M.

21. I hereby certify that I attended the deceased from April 27, 1940 to May 2, 1940;
 that I last saw him alive on May 2, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death
Tuberculous Meningitis
Pulmonary tuberculosis
Miliary Tuberculosis
 Due to _____
 Due to _____

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

Major findings at autopsy _____
Of operations _____
Of autopsy Miliary Tuberculosis

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? _____

23. Signature [Signature]
 Address 1515 Lafayette Date signed 5/2/40

Duration 10d?
PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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 Edwin H. Lubin

Licensed Embalmer No. 14014

P. O. Address Lebit Chippewa

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.