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7-39
X2169

Registration District No. 791

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Enroute Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Victoria Lee
(b) If veteran, name war _____ (c) Social Security No. 550

4. Sex Female 5. Color or race Negro
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 26 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 4 15 hr. _____ min.

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

10. Usual occupation Nil

11. Industry or business _____

12. Name M. Lee
13. Birthplace Summerville Tenn.
(City, town, or county) (State or foreign country)
14. Maiden name Anna Williams
15. Birthplace Summerville Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Marion Lee
(b) Address 3941 Finney, Ave.

17. (a) Burial (b) Date thereof 5-16-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director E. L. Garner
(b) Address 2829 Washington, Ave.

19. (a) MAY 16 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3200 Pine, St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
no attending physician
20. DATE OF DEATH: Month May day 11th
year 1940 hour 11.00 minute A. M.

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

Immediate cause of death:
Chronic Myocarditis;
Arterio Sclerosis.

Due to _____
Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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)
(c) Means of injury 5

23. Signature [Signature] (M. D. or other)
Address [Signature] Date signed 5/16/40

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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 Robert A. Powell.
Licensed Embalmer No. 3402
P. O. Address 3100 Franklin

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.