

LED AUG 25 1943

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:
(a) County Washington
(b) City or town Rural
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Washington
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

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

4. Sex M 5. Color or Race W
6. (a) Single, widowed, married, divorced 0
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 25 43
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
33 hr. min.
9. Birthplace Washington Co
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
12. Name Thomas Lee
13. Birthplace Washington
(City, town, or county) (State or foreign country)
14. Maiden name Golda TB Abbit
15. Birthplace Franker Co
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas Lee
(b) Address Mineral Point Mo.
17. (a) Burial (b) Date thereof June 23 43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hopewell
18. (a) Signature of funeral director C. F. Sparks
(b) Address Patton Mo
19. (a) 8-15-43 (b) Mrs J. P. Yeargan
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 22
year 43 hour 06 minute 30 A.M.
21. I hereby certify that I attended the deceased from 7-12-43
7-22-43 1943
that I last saw alive on 7-20- 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Unobstructed heart trouble
Duration
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____
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 J. P. Yeargan (M. D. or other) _____
Address Patton Mo Date signed 8-15-43

MOTHER FATHER

809

RECEIVED

District Health Officer, No. 4
District File Number 843-2
Date Filed 8-23-4

A. 8

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.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.

Registration District No. (886)

Primary Registration District No. (6178)

PLACE OF DEATH:
(a) County Washington
(b) City or town Concordia, Mo.
(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

3. (a) PRINT FULL NAME Donald Ray Allee
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years _____ months _____ days _____ (Year)
7. Birth date of deceased June 25 (Month) (Day) (Year)
8. AGE: Years _____ Months _____ Days _____ (Unless than one day)

9. Birthplace Washington, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
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)

15. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director J. P. Yeargan
(b) Address _____
19. (a) _____ (b) Emile Yeargan (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Washington
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 2 year 1943 minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Abnormal heart trouble
Due to congestive
Due to _____
Other conditions (Include pregnancy within 3 months of death) 157e

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? _____
(Specify type of place) _____ (e) Means of injury _____
23. Signature J. P. Yeargan (M. D. or other) _____
Address _____ Date signed 8-26-43

SUPPLEMENTARY

MOTHER-FATHER

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

29602