

41316

S. No. 2
4-2-43
5-17-39
PI X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5502
Registrar's No.

Registration District No. 194449

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital No. 20
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10-24-43-12-18-43
(Specify whether years, months or days)

In this community 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1511 Tracy
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME VIRGIL LEE

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 1 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>3</u>	<u>17</u>	hr. _____ min.

9. Birthplace Clay Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Ellis Lee

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

14. Maiden name Anna Unknown

15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Funeral (b) Date thereof 12-24-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 1511 Tracy
19. (a) 12-24-43 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 18
year 1943 hour 5:40 minute A. M.

21. I hereby certify that I attended the deceased from October 24, 1943, to December 18, 1943
that I last saw him alive on December 18, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Bronchopneumonia

Due to Post Operative Hypertrophic Prostate

Due to _____
Other conditions 1370
(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)
Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address 1511 Tracy #2 600 E 22 Date signed 12/24/43

Duration _____
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.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.