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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 4360

FILED FEB 3 1944

Registration District No. 3 1944 Primary Registration District No. 6076 Registrar's No. 193

**1. PLACE OF DEATH:**

(a) County St Louis

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

(c) Name of hospital or institution: Robert O Koch Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 yr, 1 mo, 19 days (Specify whether In this community 19 years years, months or days)

**2. USUAL RESIDENCE OF DECEASED:** 000

(a) State Missouri (b) County — 17

(c) City or town St Louis 9 (If outside city or town limits, write "RURAL")

(d) Street No. 2947 a Thomas (If rural, give location)

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

If yes, name country /

3. (a) PRINT FULL NAME LEE, WILLIAM W.

3. (b) If veteran, name war

3. (c) Social Security No. 481-18-07

4. Sex M

5. Color or race C

6. (a) Single, widowed, married, divorced S D

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan (Month) 17 (Day) 1918 (Year)

8. AGE: Years 26 Months 0 Days 6 If less than one day hr. min.

9. Birthplace LICINIA (City, town, or county) ARK / (State or foreign country)

10. Usual occupation maintenance man

11. Industry or business

FATHER
12. Name TROY LEE
13. Birthplace GLASS (City, town, or county) MISS / (State or foreign country)

MOTHER
14. Maiden name MARY HAMILTON
15. Birthplace NATCHEZ (City, town, or county) MISS / (State or foreign country)

16. (a) Informant Hospital Record

(b) Address Robert Koch Hosp.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-93 (Month) (Day) (Year)

(c) Place: burial or cremation Washington, PK. Cem.

18. (a) Signature of funeral director Ellis Funeral Home

(b) Address 2820 Stoddard St

19. (a) JAN 25 1944 (Date received local registrar) (b) E. G. McGavran M.D. (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan day 23 year 1944 hour 5 minute 36 A.M.

21. I hereby certify that I attended the deceased from Dec 24, 1942 to Jan 23, 1944; that I last saw him alive on Jan 23, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis — Duration 3 yrs?

Due to

Due to

13 P 1

Other conditions Bone Tuberculosis (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Pulm. Tuberculosis

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Frank Cohen (M. D. or other)

Address Robert Koch Hosp Date signed 1/23/44

(Licensed Embalmer's Statement on Reverse Side)

FEB 7 1944

## 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~~ L Boyk

....., Registered Apprentice No. ....., working under my personal supervision.

Signed Tommie Boykin

Licensed Embalmer No. 2946

P. O. Address St Louis Mo

**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.**