

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 53

FILED FEB 13 1945  
Registration District No. 128

Primary Registration District No. 5466

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
9  
6  
0

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town S. Campbell Twp.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: OZARK OSTEOPATHIC HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Greene

(c) City or town FAIR GROVE, MO  
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. #2  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MR. Charley H. Lee

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 18  
year 1945 - 11 hour 10 minute A. M.

21. I hereby certify that I attended the deceased from Jan 11, 1945 to Jan 18, 1945  
that I last saw him alive on Jan 18, 1945  
and that death occurred on the date and hour stated above.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife NEATIE A. LEE

6. (c) Age of husband or wife if alive 63 years  
1857

7. Birth date of deceased SEPT. 6,  
(Month) (Day) (Year)

Immediate cause of death uremia following  
Superpubic cystostomy  
1-11-45, Prostectomy  
1-1-16-45

Other conditions 12/18  
(Include pregnancy within 3 months of death)

8. AGE: Years 87 Months 4 Days 12  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation FARMER

11. Industry or business FARMING

12. Name JOSHUA LEE

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

14. Maiden name Janet Hunk

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

16. (a) Informant John Lee

(b) Address Fair Grove Mo.

17. (a) burial  
(Burial, cremation, or removal)

(b) Date thereof Jan. 24, 45  
(Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Ridge Cem.

18. (a) Signature of funeral director J.W. Klugher

(b) Address Springfield Mo.

19. (a) 1-22-45  
(Date received local registrar)

(b) W. H. Handley  
(Registrar's signature)

Major findings: Enlarged prostate

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)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature William A. Webb (M. D. or other) no

Address 2100 S. Hazen St. Date signed \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Spill, Mo.

MAR - 2 1945

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**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..... *Ogle Stone Jr.*  
Licensed Embalmer No. *4176*  
P. O. Address..... *Springfield*

**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.**

*X*