

S. No. 2  
OM-5-43  
v. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **14961**

**FILED** MAY 10 1946  
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3902**

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days  
(Specify whether  
In this community 28 years  
x years, months or days)

3. (a) PRINT FULL NAME Lee Lockett

3. (b) If veteran, name war.....

3. (c) Social Security No. 500-30-3038

4. Sex Male

5. Color or race Col

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

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive 2 years  
(Day) (Year) 1900

7. Birth date of deceased 7 2 1900  
(Month) (Day) (Year)

8. AGE: Years 45 Months 9 Days 27  
If less than one day  
..... hr. .... min.

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

10. Usual occupation Laborer

11. Industry or business.....

MOTHER FATHER

12. Name Ike Lockett

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

14. Maiden name Jessie Edward

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

16. (a) Informant Jessie Simons

(b) Address 1317 1/2 N. 8th Street

17. (a) Buried (b) Date thereof 4-30-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cemetery

18. (a) Signature of funeral director C. S. Lowe

(b) Address 2930 Dickson St.

19. (a) APR 30 1946 (b) J. F. Bradeek  
(Date received from Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St Louis 21 17  
(If outside city or town limits, write "RURAL")

(d) Street No. 1317 1/2 No 22nd St 9  
(If rural, give location) 10

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27  
year 1946 hour 7 minute A.M.

21. I hereby certify that I attended the deceased from  
April 25, 19 46 to April 27, 19 46  
that I last saw him alive on April 27, 19 46  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Arteriosclerotic Heart Disease with Unk  
Coronary Insufficiency

Due to.....

Due to.....

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

Major findings:  
Of operations.....

Of autopsy.....

Duration Unk

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 O. J. Ayer (M. D. or dentist)

Address 2601 N Whittier St Date signed 4-29-46

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

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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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 1154 Boyard Ave

**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.**