

FILED AUG 25 1946

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 3017

Registrar's No. 226

1. PLACE OF DEATH:

(a) County COOPER

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

(c) Name of hospital or institution:  
WATER STREET  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community LIFE  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County COOPER 27

(c) City or town BOONVILLE 1  
(If outside city or town limits, write "RURAL")

(d) Street No. WATER STREET 2  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 1  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JAMES W. LEE

3. (b) If veteran, name war NONE

3. (c) Social Security No. ?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 1  
year 1946 hour 9:30 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from XXXX July 25, 1946 to August 1, 1946; that I last saw him alive on July 31, 1946; and that death occurred on the date and hour stated above.

4. Sex MALE 2

5. Color or race NEGRO

6. (a) Single, married, divorced WIDOWED

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

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

7. Birth date of deceased: AUGUST 1 - 1877  
(Month) (Day) (Year)

Immediate cause of death to cancer of skin Duration 6 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>0</u>	<u>0</u>	hr. _____ min.

9. Birthplace COOPER COUNTY MISSOURI  
(City, town, or county) (State or foreign country)

10. Usual occupation PLUMBER

11. Industry or business COCHRAN PLUMBING CO.

12. Name Robert Lee

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

14. Maiden name UNKNOWN

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

16. (a) Informant INSURANCE PAPERS

(b) Address ST. LOUIS, MO.

17. (a) BURIAL (b) Date thereof AUG. 5-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director STEGNER

(b) Address BOONVILLE - MO.

19. (a) 8-6-46 (b) Clay M. Morris  
(Date received local registrar) (Registrar's signature)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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 [Signature] (M. D. or other) \_\_\_\_\_

Address [Address] Date signed Aug 4

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

25546

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 8-10-46

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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 James W. Stegner  
Licensed Embalmer No. 3780  
P. O. Address Boonville, 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.

State File No. 5ept  
Registrar's No. 226

Registration District No. 82

Primary Registration District No. 3017

1. PLACE OF DEATH:

(a) County Cooper  
(b) City or town Boonville  
(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

JAMES W. LEE

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased: Aug 1 (Month) (Day) (Year)

8. AGE: Years 69 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (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)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper  
(c) City or town Boonville  
(If outside city or town limits, write "RURAL")  
(d) Street No. Water St. (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ 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: Cancer of stomach  
from chd

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_ Of operations \_\_\_\_\_

Of autopsy 466

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) (c) Means of injury \_\_\_\_\_

23. Signature R L Evans (M. D. or other) \_\_\_\_\_

Address Aug 27th - 46 Date signed \_\_\_\_\_

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

25522

SUPPLEMENTARY

MOTHER FATHER

Duration

6 mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

26676