

Registration District No. **53**

Primary Registration District No. **3010**

Registrar's No. **384**

1. PLACE OF DEATH:

(a) County **Cape Girardeau**  
 (b) City or town **Cape Girardeau**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **St. Francis Hospital**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **14 hours**  
(Specify whether years, months or days)  
 In this community **14 hours**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Pemiscott**  
 (c) City or town **Portageville (Rural)**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **P. O. Box 678**  
(If rural, give location)  
 (e) Citizen of foreign country? **No** (Yes or No)  
 If yes, name country: \_\_\_\_\_

3. (a) PRINT FULL NAME **Willie Lee**

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

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

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

7. Birth date of deceased **November 10, 1946**  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days **6** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Portageville (Rural) Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation: \_\_\_\_\_

11. Industry or business: \_\_\_\_\_

12. Name **Joseph Lee**

13. Birthplace **Vanduser, Missouri**  
(City, town, or county) (State or foreign country)

14. Maiden name **Millie Davis**

15. Birthplace **Pemiscott County, Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mary Baker**

(b) Address **P.O. Box 678, Portageville, Mo.**

17. (a) **Removal** (b) Date thereof **Nov. 17, 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Portageville, Missouri**

18. (a) Signature of funeral director **F. D. Sparks**  
**Cape Girardeau, Missouri.**

(b) Address \_\_\_\_\_  
 19. (a) **11-29-46** (b) **C. C. Summers**  
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **16**  
 year **1946** hour **8:30** minute **A.M.**

21. I hereby certify that I attended the deceased from **11/15/46** 19 to **11/16/46** 19;  
 that I last saw him alive on **11/15/46** 19;  
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Intra Cranial bleed injury** Duration **5 days**

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

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

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

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

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

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 **J. H. Cochran** (M. D. or other) \_\_\_\_\_  
 Address **Cape Girardeau, Mo.** Date signed **11/16/46**

RECEIVED

District Health Officer No. 4

District File Number 1146-2870

Date Filed 11-18-46

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 Frank Sparks

Licensed Embalmer No. 3455

P. O. Address Cape Girardeau

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 10c  
Registrar's No. 384

Registration District No. 53

Primary Registration District No. 3010

**1. PLACE OF DEATH:**  
(a) County Cape Girardeau  
(b) City or town Cape Girardeau  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

**3. (a) PRINT FULL NAME** Willie 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 S

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

7. Birth date of deceased Nov. 10 1946  
(Month) (Day) (Year)

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

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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. (c) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

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

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

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

19. (a) 11-29-1946 (b) C. C. Summers  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (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 \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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

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

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

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

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

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 \_\_\_\_\_

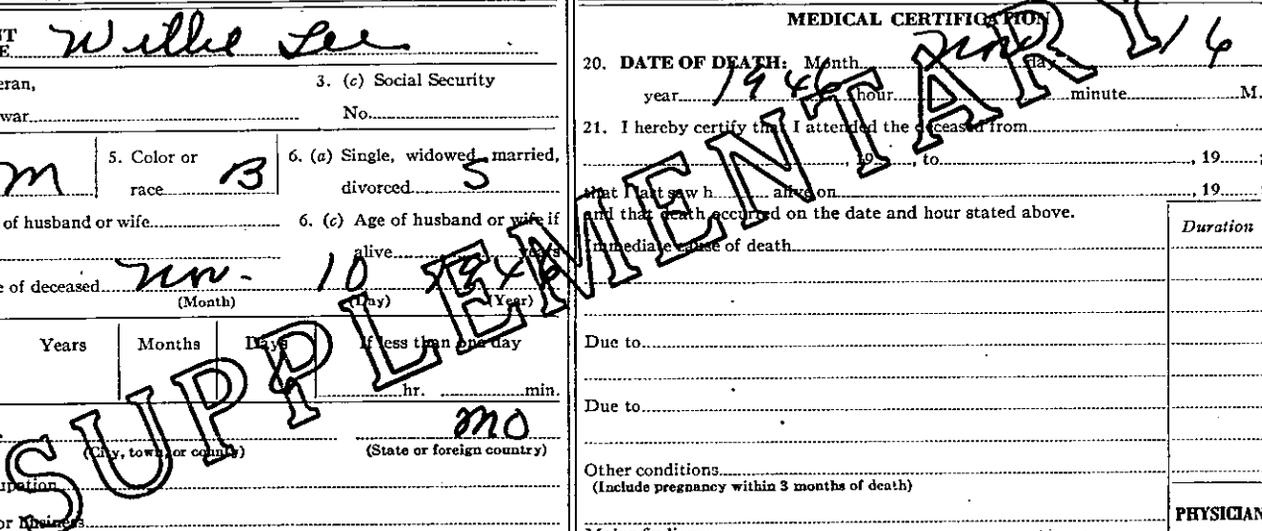
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

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

Address \_\_\_\_\_ Date signed \_\_\_\_\_



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