

FILED MAY 26 1947
 Registration District No. 1749

Primary Registration District No. 1002

Registrar's No. 2122

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. 19 days
(Specify whether years, months or days)
 In this community 45 yrs

3. (a) PRINT FULL NAME James Lee
 3. (b) If veteran, name war no
 3. (c) Social Security No. none

4. Sex Male
 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife No Record
 6. (c) Age of husband or wife if alive 1884 years
 7. Birth date of deceased Jan 15 1884
(Month) (Day) (Year)

8. AGE: Years 63 Months 3 Days 25
If less than one day hr. min.

9. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Relief Circulation Dept
 11. Industry or business Kansas City Star

MOTHER FATHER
 12. Name Lee
 13. Birthplace No Record
(City, town, or county) (State or foreign country)
 14. Maiden name No Record
 15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Phoebe Jane Rizer
 (b) Address Nevada Mo
 17. (a) Removal Removal
 (b) Date thereof May 13-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lathrop, Mo.
 18. (a) Signature of funeral director Mr C H Foster
 (b) Address 918 Brooklyn

19. (a) 5-13-47 (b) Heraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 523 W. 12 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 May day 10
 year 1947 hour 3 minute 55 A. M.

21. I hereby certify that I attended the deceased from April 21 1947 to May 10 1947
 that I last saw him alive on May 10 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular accident
 Duration _____

Due to _____
 Due to _____
 Other conditions 830
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy None
 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? 0

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature Wm W Hart (M. D. or other) MD
 Address Med. Dir. Gen'l Hosp. Date signed 5-10-47

1848
MAY 3
1848

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..... *Dean Owens*

Licensed Embalmer No. *4280*

P. O. Address..... *918 Brooklyn
R.C., 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.