. S. No. 2
M—1/47
v. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39896

FILED DEC 15 1947

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 11083

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 11 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 3525 Laclede (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Robert J. Lite
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Bessie Tite
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct. (Month) 11 (Day) 1893 (Year)

8. AGE: Years	Months	Days	If less than one day
54	1	19	hr. min.

9. Birthplace Texas (City, town, or county) (State or foreign country)
10. Usual occupation Nil
11. Industry or business
FATHER 12. Name R. J. Lite
13. Birthplace Texas (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Janie ?
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Bessie Lite
(b) Address 3525 Laclede ave
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-5-47 (Month) (Day) (Year)
(c) Place: burial or cremation E. St. Louis Ill
18. (a) Signature of funeral director
(b) Address 3517 Laclede ave
19. (a) DEC 3 - 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 30 year 1947 hour 5 minute 15 p. M.
21. I hereby certify that I attended the deceased from Nov. 19 1947 to Nov. 30 1947 that I last saw him alive on Nov. 30 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Thrombosis	Undet.
Osteomyelitis of Lumbar Spine	"
Non-Tubercular	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Benign Hypertrophy of Prostate	

Major findings:
Of operations
Of autopsy No

PHYSICIAN: Underline the cause of 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 John D. Clayper (M. D. or other)
Address 2601 N. Vokuttus Date signed 12/1/47
JOHN D. CLAYPER

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 Melvin E. Green

Licensed Embalmer No. 4428

P. O. Address St. Louis, 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.