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FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6394

State File No.

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1335**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5520 Lansdowne		d. STREET ADDRESS (If rural, give location) 5520 Lansdowne Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Julia	b. (Middle) Martha	c. (Last) Lee	4. DATE OF DEATH (Month) (Day) (Year) 2 10 1949
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Aug. 25, 1893
9. AGE (In years last birthday) 55		IF UNDER 1 YEAR Months Days	IF UNDER 12 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) St. James, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME James Monroe Lee	13b. MOTHER'S MAIDEN NAME Mary E. Will	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Leona M. Lee,	ADDRESS 5520 Lansdowne Ave.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage, right side (Massive)		2 years
	ANTECEDENT CAUSES DUE TO (b) Brain Tumor, 8th nerve Fibures <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> unqual. fix'd DUE TO (c) Amputated legs (both above knees-Removed)		5 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None		Thrombosis	5 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION None	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb. 9, 1949**, to **Feb. 11, 1949**, that I last saw the deceased alive on **Feb. 10, 1949** and that death occurred at **11:30 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE Scott Haver, M.D. (Degree or title)	23b. ADDRESS 634 W. Grand Blvd.	23c. DATE SIGNED 2-11-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-13-49	24c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery	24d. LOCATION (City, town, or county) (State) St. James, Mo.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE FEB 11 1949 J. B. Basater	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe,	ADDRESS 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Clement McNeary*

Licensed Embalmer No. *3732*

P. O. Address *St. Louis*

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.