

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3389**
Registrar's No. **0494**

FILED FEB 11 1953

318 1003

BIRTH NO. REG. DIST. NO. PRIMARY REG. DIST. NO.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Ferguson	
c. LENGTH OF STAY (In this place) 3 days		d. STREET ADDRESS (If rural, give location) 361 Plaza	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Robert	b. (Middle) Emmett	c. (Last) Lee	4. DATE OF DEATH (Month) (Day) (Year) 1--15--1953
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5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 1-8-1888	9. AGE (In years last birthday) (Specify) 65	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector	10b. KIND OF BUSINESS OR INDUSTRY Carter Carburetor	11. BIRTHPLACE (State or foreign country) Mexico, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Edward Lee	13b. MOTHER'S MAIDEN NAME Lillian Avery	14. NAME OF HUSBAND OR WIFE Grace Fette Lee
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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. 493-10-5190	17. INFORMANT'S SIGNATURE OR NAME Mrs. Grace Lee, Ferguson, Mo	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs. 18 da.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Thrombophlebitis of Rt Leg		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 464X
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22. I hereby certify that I attended the deceased from **1-5, 1953**, to **1-14, 1953** that I last saw the deceased alive on **1-14, 1953** and that death occurred at **4:30 PM**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. H. Weaver M.D.	23b. ADDRESS 90 N. 7th - Ferguson	23c. DATE SIGNED 1-15-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 1-17-1953	24c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. JAN 16 1953	REGISTRAR'S SIGNATURE Charles Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE White Chapel, Ferguson, Mo.	ADDRESS
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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 _____

Elena Province

Licensed Embalmer No. 3423

P. O. Address Jessup 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.