

FILED JAN 27 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44269

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>548</u>		Registrar's No. <u>2934</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Webster Groves</u>		c. LENGTH OF STAY (in this place) <u>12 yrs</u>		c. CITY OR TOWN <u>Webster Groves</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Res 712 Marshal Ave</u>				e. STREET ADDRESS (If rural, give location) <u>712 Marshal Ave.</u>			
3. NAME OF DECEASED a. (First) <u>Dr. Floyd</u>			b. (Middle) <u>B.</u>		c. (Last) <u>Lee</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 19, 1954</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct. 23, 1878</u>		9. AGE (In years last birthday) <u>76 yrs</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Educator & Chemist</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>SCIENTIST</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Louisburg, Kansas</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>James T. Lee</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Brown</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Mary Brown Lee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mary Brown Lee</u>		ADDRESS <u>712 Marshal Ave.</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		<p align="center">MEDICAL CERTIFICATION</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u> <u>Cerebral Thrombosis</u> <u>Diabetes Mellitus</u></p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS <u>Hypertension</u> Conditions contributing to the death but not related to the disease or condition causing death.</p>				INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>26 years</u> <u>years.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____	
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 <u>6/9</u> , 19 <u>53</u> , to <u>12-19</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>12/19</u> , 19 <u>54</u> , and that death occurred at <u>7 p</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Victor Reese</u>			23b. ADDRESS (Degree or title) <u>M.D.</u> <u>120 E Lockwood</u>		23c. DATE SIGNED <u>12/20/54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		24b. DATE <u>Dec. 21, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crematory</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>		
DATE REC'D BY LOCAL REG. <u>12-21-54</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Donke M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Gleffender & Sons 617.5 Delmar</u> ADDRESS _____			

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

Dr A Victor Reese
120 E Lockwood
4-6

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.....
Signature of Student Embalmer

Signed *Stanley H. Dixon*.....

Licensed Embalmer No. *419*.....

P. O. Address *St. L.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.