

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **6295**BIRTH NO. **18390-55** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1744**

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, Mo		c. LENGTH OF STAY (In this place) 3 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis - 7		2269			
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital				d. STREET ADDRESS (If rural, give location) 26 3435 a. KLEIN STREET.					
3. NAME OF DECEASED (Type or Print) a. (First) DANIEL		b. (Middle) FRANKLIN		c. (Last) LEE		4. DATE OF DEATH (Month) (Day) (Year) 2 - 22 - 55			
5. SEX m	6. COLOR OR RACE w	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0		8. DATE OF BIRTH 2 - 19 - 55		9. AGE (In years last birthday) 28 MONTHS 8 DAYS 50 HOURS 50 MIN.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME FRANKLIN Preston LEE			13b. MOTHER'S MAIDEN NAME FARLINE CLYBB			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS FARLINE LEE, 3435 a. KLEIN, St. Louis, Mo					
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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) respiratory failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) bronchitis DUE TO (c) new born II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 3 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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? 7730					
22. I hereby certify that I attended the deceased from 2 - 19, 1955 , to 2 - 22, 1955 , that I last saw the deceased alive on 2 - 22, 1955 , and that death occurred at 4:30 P. m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Carl Smith M.D.				23b. ADDRESS 35 n. Central, Clayton		23c. DATE SIGNED 2/23/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Feb 23, 1955		24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.			
DATE REC'D BY LOCAL REG. FEB 23 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Alexander & Sons 6175 Delmar					

(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 _____

working under my personal supervision.

No Embalment

Student Embalmer No. _____

Student
Student Embalmer

Signed *J. E. McCulloch*

Licensed Embalmer No. *2760*

P. O. Address *6140 Pll*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.