

FILED NOV 13 1957

Registration District No. 128 Primary Registration District No. 2070 Registrar's No. 1061

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b> (Permit)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1900 N. Lyon st.</b>		Length of stay in 1b <b>34 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>1900 N. Lyon</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>EMANUEL F. LEE</b>			4. DATE OF DEATH Month Day Year <b>Oct. 31, 1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 20, 1880</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>man Eagles Lodge</b>	11. BIRTHPLACE (City and state or country) <b>Dallas County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Stephen Lee</b>		13b. MOTHER'S MAIDEN NAME <b>Viola Guthrie</b>		14. NAME OF HUSBAND OR WIFE <b>* * * * *</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Miss Ressie Lee, 1900 N. Lyon</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Circulatory Failure</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Thrombosis</b>					
DUE TO (c) <b>Arteriosclerosis</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arthritis of Lumbar Area and Right Hip. 4201</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>Feb 18 1948</b> to <b>Oct 31 1957</b> and last saw her alive on <b>Oct 23 1957</b> Death occurred at about <b>3:00 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Dr. D. F. Youll</i> Dr. <b>D. F. Youll</b>		(Degree or title)	22b. ADDRESS <b>234 1/2 E. Commercial Springfield, Missouri</b>		22c. DATE SIGNED <b>11-6-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-2-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Clear Creek Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Greene County, Missouri</b>
24. FUNERAL DIRECTOR <b>AYRE-GOODWIN, Inc. Springfield</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>11-8-57</b>	26. REGISTRAR'S SIGNATURE <i>Edith Williamson</i>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

OCT 4 1961

NOV 7 8 1961

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 *Lucian T. Shadley*

Licensed Embalmer No. *4815*

P. O. Address *Springfield*

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.