

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-003705

FILED VS JAN 29 1960

2 669

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO</u> | | Length of stay in 1b | c. CITY OR TOWN <u>St. Louis.</u> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>715a Market, St.</u> |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>YEE NAM LEE</u> | | | 4. DATE OF DEATH Month Day Year <u>JAN, 16, 1960</u> | | | |
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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Yellow</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>???</u> <u>1878</u> | 9. AGE (last birthday) <u>81</u> | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Vendor</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>California</u> | 12. CITIZEN OF WHAT COUNTRY <u>?</u> |
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| 13a. FATHER'S NAME <u>Unknown</u> | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>Wong Shee</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No.</u> | 16. SOCIAL SECURITY NO. <u>Nil.</u> | 17. INFORMANT <u>Joe Jone, 2549 Tyrell, Dr.</u> | Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) | <u>Pulmonary Embolism (acute)</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | <u>Arteriosclerotic Heart Disease.</u> | |
| DUE TO (b) | <u>Generalized arteriosclerosis</u> | |
| DUE TO (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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.) <u>420-0</u> |
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|---|--|--|------------------------------|--------|-------|
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <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 |
|---|--|--|------------------------------|--------|-------|

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| 21. I attended the deceased from <u>1/12/60</u> to <u>1/16/60</u> and last saw her/him alive on <u>1/16/60</u> | |
| Death occurred at <u>7:05 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | |

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| 22. SIGNATURE (Degree or title) <u>Paul J. Stern, M.D.</u> | 22b. ADDRESS <u>1515 LAFAYETTE AVE</u> | 22c. DATE SIGNED <u>1/18/60</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>1-20-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>Albert H. Hoppe Inc., 4700 Washington, Blvd.</u> | 25. DATE RECD. BY LOCAL REG. <u>JAN 19 1960</u> | 26. REGISTRAR'S SIGNATURE <u>Joan Smith, M.D.</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Isaac W. Wilkins

Licensed Embalmer No. 25

P. O. Address 11 South

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.