

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-029111

FILED VS JUL 22 1960

317

Primary Registration District No. 547

Registrar's No. 2008

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Mo</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>ST LOUIS</b>			
b. CITY (If outside of County, give County and City or Town) <b>Richmond Heights Mo</b>			Length of stay in lb <b>29 days</b>		c. CITY OR TOWN <b>Cool Valley</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>St Marys Hospital</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4825 N. Hills La</b>	
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>J</b> Last <b>Lee</b>				4. DATE OF DEATH Month <b>7</b> Day <b>2</b> Year <b>60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-18-99</b>	9. AGE (last birthday) <b>61</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <b>Plasterer</b>		11. BIRTHPLACE (City and state or country) <b>St Louis Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Robert E. Lee</b>			13b. MOTHER'S MAIDEN NAME <b>Sarah Sullivan</b>			14. NAME OF HUSBAND OR WIFE <b>Marie E.</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>489-09-6564</b>		17. INFORMANT Address <b>Miss Dorothy C. Lee 4825 N. Hills Lane</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) <u>Progressive Pulmonary Tuberculosis</u> DUE TO (b) <u>Broncho pneumonia &amp; multiple abscess</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>7/28/60</u> <u>7/2/60</u>	
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 type="checkbox"/> No <input type="checkbox"/> Unknown	
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.) <b>no</b>					
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	
21. I attended the deceased from <u>May 28</u> to <u>7/2/60</u> and last saw him alive on <u>7/2/60</u> Death occurred at <u>5-48</u> <u>pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Blair Ferrara M.D.</b>				22b. ADDRESS <b>Marshall Medical Bldg.</b>		22c. DATE SIGNED <b>7/3/60</b>	
23. BURIAL, CREMATION, or other disposition (Specify) <b>REMOVAL</b>		23b. DATE <b>7-5-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St Louis Mo</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Arthur J. Donnelly 3840 Lindell</b>				25. DATE RECD. BY LOCAL REG. <b>7-2-60</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

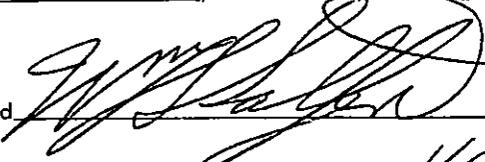
Robert Lee  
 489-09-6204 Miss Dorothy J. Lee  
 2-18-99  
 St. Mary's Hospital  
 St. Louis, Mo.  
 Marie E.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

or by \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
 Signature of Student Embalmer

Signed 

Licensed Embalmer No. 4629  
 P. O. Address 3840 L...

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.