

No. 2  
-8-43  
-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24671

State File No. \_\_\_\_\_

FILED JUL 29 1946  
Registration District No. 297

Primary Registration District No. 6022

Registrar's No. 82

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
R.F.D.# 5, Richmond, Mo. /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No  
(Specify whether)

In this community 63 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ray

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D.# 5, Richmond, Mo.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.

3. (a) PRINT FULL NAME Addie May Lee

3. (b) If veteran name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John William Lee

6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased November 7, 1882  
(Month) (Day) (Year)

8. AGE: Years 63 Months 8 Days 9  
If less than one day  
hr. \_\_\_\_\_ min.

9. Birthplace Vibbard, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Thomas M. Rimmer

13. Birthplace Ray County, Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Lucendy Price Swope  
(City, town, or county) (State or foreign country)

15. Birthplace Ray County, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant John William Lee

(b) Address Richmond, Missouri

17. (a) Burial (b) Date thereof 7/18/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunny Slope Cemetery

18. (a) Signature of funeral director Quest-Life F. Home

(b) Address Richmond, Missouri

19. (a) July 17-46 (b) M. A. L. Jackson  
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16  
year 1946 hour 11:00 minute \_\_\_\_\_ A.M.

21. I hereby certify that I attended the deceased from  
June 30, 1946 to July 16, 1946  
that I last saw her alive on July 16, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy

Due to My pertension  
partial sclerosis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration  
16 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature: D. E. J. Kerans (M. D. or other)

Address Richmond, Mo. Date signed July 16, '46

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WRITE PLAINLY—USE UNFAADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 7-27-46

**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 \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 4096

P. O. Address Richmond

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