

1939 OCT 14

Registration District No. **791**

Primary Registration District No. _____

1. PLACE OF DEATH: **1003**
(a) County _____ /
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 hour**
(Specify whether
In this community **30 Years**
years, months or days)

3. (a) PRINT FULL NAME **Lee Lay** **DD-D**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **Chinese** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **About 59**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
→ 59 hr. min.

9. Birthplace **China**
(City, town, or county) (State or foreign country)

10. Usual occupation **Cook**

11. Industry or business _____
12. Name **Unknown**
13. Birthplace **China**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **China**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **C. H. Quinn**
(b) Address **6314 Delmar**

17. (a) **Burial** (b) Date thereof **9/8/39**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Valhalla Cemetery**

18. (a) Signature of funeral director **Hacker-Welders**
(b) Address **2331 S. Broadway**

19. (a) **SEP 8 1939** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____ /
(c) City or town **St. Louis** **25**
(If outside city or town limits, write "RURAL")
(d) Street No. **#20 S. 8th St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** Day **6**
year **1939** hour **4** minute **31** a.m.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Tuberculosis**
Chronic
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically

Major findings:
Of operations _____
Of autopsy **See above**

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 **[Signature]** (M. D. or other)
Address _____ Date signed **9/8/39**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.

No Embalming

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.