

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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Ralls
Township Jasper
or
Village
or
City

Registration District No. 725 File No. 2393-a
Primary Registration District No. 3960C Registered No. 66

City (NO. _____ St. _____ Ward _____) (If death occurred in a hospital or institution, give its NAME instead of street and number)
FULL NAME Abram B. Seely

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE married
MARRIED divorced
OR DIVORCED
(Write the word)
DATE OF BIRTH Jan 18 1837
(Month) (Day) (Year)
AGE 76 yrs. 13 mos. 13 ds. IF LESS than
1 day, _____ hrs.
or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

BIRTHPLACE
(City or town, State or foreign country) Ralls Co Mo

NAME OF FATHER Abram Seely

BIRTHPLACE OF FATHER Unknown

MAIDEN NAME OF MOTHER Angeline Walsh

BIRTHPLACE OF MOTHER Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J B Inlow

(ADDRESS) Center Mo

Filed 1-20 1913

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 18 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 8, 1913, to Jan 18, 1913,
that I last saw him alive on Jan 18, 1913,
and that death occurred, on the date stated above, at 6:00 pm.

The CAUSE OF DEATH* was as follows:

Artero-sclerosis
General
99 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Harry B. Norton M. D.
Jan 19 1913 (Address) Center Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Center Mo DATE OF BURIAL 1-20 1913

UNDERTAKER J. W. Jones ADDRESS Center Mo

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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____ (NO. _____)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____ SINGLE _____ MARRIED _____ WIDOWED _____ OR DIVORCED _____ (If file the word)

DATE OF BIRTH _____

(Month) _____ (Day) _____ (Year) _____

AGE _____

IF LESS than 1 day, _____ hrs. or _____ min. ?

OCCUPATION _____

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE _____

(City or town, State or foreign country)

NAME OF FATHER _____

BIRTHPLACE OF FATHER _____

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER _____

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____

191 _____

REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

(Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191 _____, to _____, 191 _____,

that I last saw him alive on _____, 191 _____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____

191 _____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____

Where was disease contracted

If not at place of death?

Former, or usual residence _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____

UNDERTAKER _____

ADDRESS _____