

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

Do not use this space.

17228

1. PLACE OF DEATH

County Jackson Registration District No. 549 File No. 210
 Township Kaw Primary Registration District No. 1007 Registered No. _____
 City Kansas City (No. Trinity Lutheran Hosp St. _____ Ward)

2. FULL NAME Betty June Seashill

(a) Residence No. 6226 Tracy St. 15 Ward. _____
 (Usual place of abode) _____ (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) Infant

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 5, 1928

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	0	0	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas City
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER William B. Seashill

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lalina
 (STATE OR COUNTRY) Kansas

12. MAIDEN NAME OF MOTHER Mable Quinn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) Missouri

14. INFORMANT W. B. Seashill
 (Address) 6226 Tracy

15. FILED May 18 1928 M. M. Cooney
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 17 1928

17. I HEREBY CERTIFY That I attended deceased from May 7, 1928, to May 17, 1928, (that I last saw b. er. alive on May 15, 1928, and that death occurred, on the date stated above, at 6:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Purulent meningitis 32A
70A

(duration) yrs. mos. 10 da.
CONTRIBUTORY (SECONDARY) Cerebral hemorrhage
161 B (duration) yrs. mos. 12 da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
 (Signed) Charles J. Eldridge, M. D.
May 17, 1928 (Address) 711 Pathology Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wt. Washington **DATE OF BURIAL** 5-18-1928

20. UNDERTAKER J. P. Lewis **ADDRESS** City

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

