DEC 22 1930

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

Do not use this space.

36795

1. PLACE OF DEATH

County: Marion — Registration District No.: 597 — File No.:

Township: Mason — Primary Registration District No.: 3029 — Registered No.: 398

City: Hannibal (No. Levering Hospital St. 6 Ward)

2. FULL NAME Curtis M. Seabaugh

(a) Residence. No. 1425 Pearl St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Catherine

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept 24-1878

7. AGE: 52 YEARS — MONTHS: 1 — DAYS: 18 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Cape County Mo

PARENTS

10. NAME OF FATHER: Joseph Seabaugh
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Minnie Presnell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ill

14. INFORMANT: Mrs. Catherine Seabaugh
(Address) 1425 Pearl St. Hannibal Mo

15. FILED 11/28, 1930 [signature], REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 11/22 1930

17. I HEREBY CERTIFY, That I attended deceased from 11-19, 1930, to 11-22, 1930 that I last saw him alive on 11-22, 1930, and that death occurred, on the date stated above, at 9:22 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cirrhosis of liver — atrophic
19 M-B
118-2
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Gastric hemorrhage
(duration) yrs. mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 12 B 1
DID AN OPERATION PRECEDE DEATH? No. DATE OF —
WAS THERE AN AUTOPSY? Yes —
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Howard B. Goodrich, M.D.
11-22 1930 (Address) Hannibal, Mo

*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: Mt Olivet Cem. — DATE OF BURIAL: 11/25 1930

20. UNDERTAKER: James O'Donnell — ADDRESS: Hannibal

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
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CERTIFICATE OF DEATH

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File No. .....

Registered No. .....

1. PLACE OF DEATH

(County) ..... Registration District No. .....

Township ..... Primary Registration District No. .....

(City) ..... (No. ..... St. ..... Ward)

2. FULL NAME .....

(a) Residence. No. ..... St. ..... 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed or Divorced (write the word)

5a. If Married, Widowed, or Divorced
HUSBAND or
(or) WIFE of

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

7. AGE Years	Months	Days	If Less than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(Address)

15. Filed ....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D
, 19 (Address)

*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	DATE OF BURIAL
	19

20. UNDERTAKER	ADDRESS

K.B.—Every item of information should be carefully gathered and filed in ink, or a typewriter. Erasures to correct mistakes should be made with a pen. ADD phone numbers. Legibility is vital in order that this record may be photographed.

CAUSE OF DEATH PHYSICIAN MOTIVATION. Please ensure physicians understand the importance of this section.