

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

Do not use this space.

36812

**1. PLACE OF DEATH**

89 County Putnam  
6 Township Richmond  
4 City Richmond (No. .... St. .... Ward)

Registration District No. 744  
Primary Registration District No. 3035

File No. 81  
Registered No. ....

**2. FULL NAME** Samuel J. Seck

(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 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 May Jane Seck

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 28 1858

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
74 / 10 / 15

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Fanner  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

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

10. NAME OF FATHER John K. Seck

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

12. MAIDEN NAME OF MOTHER Polly Robinson

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

14. INFORMANT Mrs. May Jane Seck (Address) Richmond, Mo.

15. FILED 12-9-1932 E. G. Day REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 13-1932

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to Nov 13, 1932 that I last saw him alive on ..... 19..... and that death occurred, on the date stated above, at 8:25 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Apoplexy  
92A John Seck (duration) yrs. mos. 10 ds.  
CONTRIBUTORY (SECONDARY) John Seck (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED (5)  
IF NOT AT PLACE OF DEATH. ....

0 DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No  
WHAT TEST CONFIRMED DIAGNOSIS? Clinical History

(Signed) W. M. Jones M. D.

Nov 14, 1932 (Address) Rayville, 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 M. C. Donald Care DATE OF BURIAL 11/15/32

20. UNDERTAKER C. M. Jones ADDRESS Richmond, Mo.

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.

JAN 9 1933

