

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**

APR 26 1935

Do not use this space.

✓  
 11550  
 File No. 46  
 Registered No. \_\_\_\_\_  
 \_\_\_\_\_ St. \_\_\_\_\_ Ward

**1. PLACE OF DEATH**

County Schuyler Registration District No. 806  
 Township \_\_\_\_\_ Primary Registration District No. 4482  
 City Glenwood (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Frank M. See

(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 Etta See  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 6 - 1872  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
62      5      4  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

OCCUPATION  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Glenwood Mo.  
 13. NAME Jas. See  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known  
 15. MAIDEN NAME Susan Welborn  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
 17. INFORMANT (ADDRESS) Mrs. Frank See  
Glenwood, Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Liberty Cemetery DATE Mar. 11, 1935  
 19. UNDERTAKER (ADDRESS) J. Lynn A. Roberts  
Lancaster Mo.  
 20. FILED Mar. 14, 1935 Byrdie K. Drake  
Deputy Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 10, 1935  
 22. I HEREBY CERTIFY, That I attended deceased from 7 am, 1935, to Mar. 10<sup>th</sup>, 1935  
 I last saw him alive on Mar. 10<sup>th</sup>, 1935 Death is said to have occurred on the date stated above, at 11:30 A.M.  
 The principal cause of death and related causes of importance were as follows:

Malignancy of Eye, and cholelithiasis  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance:  
Coronary thrombosis Ten years ago

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? Yes  
 If so, specify \_\_\_\_\_  
 (Signed) Carl D. Gordon, M. D.  
 (Address) Lancaster Mo.

[The body of the page contains extremely faint and illegible text, likely bleed-through from the reverse side of the document. The text is too light to be transcribed accurately.]

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

Do not use this space.  
ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENT.  
File No. \_\_\_\_\_  
Registered No. 4482 St. \_\_\_\_\_ Ward \_\_\_\_\_

**1. PLACE OF DEATH**

County Schuyler  
Township \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_)

Registration District No. 805  
Primary Registration District No. 4482

**2. FULL NAME**

Frank M. See

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
62 5 4

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_

19. UNDERTAKER (ADDRESS)

20. FILED June 8, 1935 A. J. Drake Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 10, 1935

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

malignance of eye and chest  
because of eye  
eye is primary seat of malignance  
Other contributory causes of importance: \_\_\_\_\_

Date of onset

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

(Address) \_\_\_\_\_

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.

JUN 4 1968

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