

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.

DEC 21 1935

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

Do not use this space.

1. PLACE OF DEATH

County Perry  
Township Salem  
City Farrar (No. \_\_\_\_\_)

Registration District No. 662  
Primary Registration District No. 5880

File No. 36933  
Registered No. 11  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Allen Dee Seever

(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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 22nd, 1935

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
No 6 8

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None  
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) Farrar, Mo

MOTHER FATHER 13. NAME Gerdinand Carl Seever

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

15. MAIDEN NAME Hilda Elba Schultz

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

17. INFORMANT F. C. Seever (ADDRESS) Farrar, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Farrar Mo DATE Dec 2nd 35

19. UNDERTAKER Young & Seever (ADDRESS) Farrar Mo

20. FILED Dec 2nd 1935 J. P. De Laven Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 30th, 1935

22. I HEREBY CERTIFY, That I attended deceased from November 28th, 1935, to November 30th, 1935

I last saw him alive on November 30th, 1935 Death is said

to have occurred on the date stated above, at 10 P. m.

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

Broncho-Pneumonia Date of onset 3 days

Other contributory causes of importance: \_\_\_\_\_

Name of operation None Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No

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 Theodore Fischer, M. D.

(Signed) \_\_\_\_\_ (Address) Altamont, Mo



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY

1. PLACE OF DEATH

County Perry Registration District No. 662 File No. \_\_\_\_\_  
Township Salem Primary Registration District No. 3880 Registered No. \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Allan Lee Seewers  
(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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 30 1935

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

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

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

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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

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

8. Trade, profession, occupation, kind of work done, spinner, weaver, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date of onset Bronchopneumonia

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

11. Total time (years) spent in this occupation

Other contributory causes of importance: None

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

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

13. NAME

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

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

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

15. MAIDEN NAME

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

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

Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS)

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

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

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

19. UNDERTAKER (ADDRESS)

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

20. FILED 12-2-35 J. P. DeLoans Registrar

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

(Signed) Theodore Fischer, M. D.  
(Address) Altenburg mo

