

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.

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

18250  
Do not use this space.

JUN 19 1939

1. PLACE OF DEATH

(a) County Cape Girardeau 1 Registration District No. 125  
(b) Township Cape Girardeau Primary Registration District No. 3009  
(c) City Cape Girardeau Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 179

2. PRINT FULL NAME

Justine May Seabough  
(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 15, 1939  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, 1.2 hrs. or min. 1

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as 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) South East Hospital Cape Girardeau, Mo.

13. NAME Howard H. Seabough

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Grinstead Mo.

15. MAIDEN NAME Milched M. Horseshoe

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

17. INFORMANT (ADDRESS) Howard H. Seabough Jackson, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE New Salem DATE May 16, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Cramer & Miller Jackson Mo. 125

20. FILED J-16 1239 gm Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-16 1939

22. I HEREBY CERTIFY, That I attended deceased from 5-15, 1939, to 5-15, 1939

I last saw h. e. r. alive on 5-15, 1939. Death is said to have occurred on the date stated above, at 4:30 pm. The principal cause of death and related causes of importance were as follows:

Pneumonia (7 mo)

Other contributory causes of importance: 154

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) H. Seabough, M. D.  
(Address) Jackson, Mo.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, \_\_\_\_\_

\_\_\_\_\_, or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**