

REC'D JUN 14 1939

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

19668

Do not use this space.

1. PLACE OF DEATH

(a) County..... St. Francois Co. / Registration District No. 773
(b) Township..... St. Francois Primary Registration District No. 6018A
(c) City..... Near Farmington (d) Street No. State Hospital No. 4 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.

2. PRINT FULL NAME B. R. Seabaugh

(a) Residence, No. Cape Girardeau, Mo. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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 Bertha M. Seabaugh

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-13-1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
53 10 23

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
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) Sedgewickville,
(STATE OR COUNTRY) Missouri

13. NAME Joseph Seabaugh

14. BIRTHPLACE (CITY OR TOWN) Sedgewickville,
(STATE OR COUNTRY) Missouri

15. MAIDEN NAME Polly Ann Crites

16. BIRTHPLACE (CITY OR TOWN) Oak Ridge, Mo.
(STATE OR COUNTRY) Missouri

17. INFORMANT Records of State Hospital No. 4
(ADDRESS) Farmington, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE. Cape Girardeau, Mo. DATE 5-8 1939

19. FUNERAL DIRECTOR (NAME) Seabaugh Fun Home
(ADDRESS) Cape Girardeau

20. FILED May 10, 1939 T. B. Robinson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-6 1939

22. I HEREBY CERTIFY, That I attended deceased from May 10, 1939, to 5-6, 1939

I last saw him alive on 5-6, 1939. Death is said

to have occurred on the date stated above, at 5:30pm.
The principal cause of death and related causes of importance were as follows:

Hypostatic bronchopneumonia Date of onset
Fracture of left femur W

Other contributory causes of importance:

General paresis

Name of operation _____ Date of _____

What test confirmed diagnosis? Lab. & Clin. Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide accident Date of injury 4-15, 1939

Where did injury occur? on ward of hospital
(Specify city or town, county, and State)

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

Manner of injury slipped and fell
Nature of injury Fracture of left femur

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify Paul J. Schradin

(Signed) _____, M. D.

(Address) Farmington, Mo.

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.....

W. H. Estes

Registered Apprentice No.....

working under my personal supervision.

Signed.....

W. H. Estes

Licensed Embalmer No. *3568*

P. O. Address *Cape Girardeau*

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

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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19668
Do not use this space.

1. PLACE OF DEATH

(a) County St. Francois Registration District No. 773
 (b) Township St. Francois Primary Registration District No. 60.18A Registered No. 87
 (c) City _____ (d) Street No. _____
 (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.

2. PRINT FULL NAME

(a) Residence, No. B. ROBERT BARNIE SEABAUGH
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-6-1939

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.
33 10 23

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

OCCUPATION 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

Date of onset

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

Other contributory causes of importance:

FATHER 13. NAME

Name of operation ... Date of ...

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

What test confirmed diagnosis? ... Was there an autopsy? ...

MOTHER 15. MAIDEN NAME

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

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

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

17. INFORMANT (ADDRESS)

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

18. BURIAL, CREMATION, OR REMOVAL

Manner of injury ...

PLACE DATE

Nature of injury ...

19. FUNERAL DIRECTOR (ADDRESS)

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

20. FILED July 26, 1939 T. B. Robinson Local Registrar

If so, specify (Signed) Paul J. Schuyler, M. D.

(Address) Farmington Mo.

SUPPLEMENTARY

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

