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

28085
Do not use this space.

1. PLACE OF DEATH — DEC 10 SEP 6 1939
(a) County Jackson 1 — Registration District No. 399
(b) Township Kaw 1 — Primary Registration District No. 1902 — Registered No. 3087
(c) City Kansas City 1 — (d) Street No. General Hospital #2 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 420 George Seals
(a) Residence, No. 911 E. 24 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: Male
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Dorothy Seals
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Jan. 29, 1915
7. AGE: YEARS 24 — MONTHS 6 — DAYS 2 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Deliveryman
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): Van Buren Arkansas 1

FATHER
13. NAME: William Seals 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Van Buren Ark. 1

MOTHER
15. MAIDEN NAME: Nellie Mitchell
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Van Buren Ark.

17. INFORMANT (ADDRESS): Nellie Frazier 911 E 24 St.
18. BURIAL, CREMATION, OR REMOVAL PLACE: Lincoln Cem. DATE 8/3 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): West, Appleton & Jones, 1965 Vine
20. FILED 8/2 1939 M. M. Crowe, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 7-31, 1939
22. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19....
I last saw [illegible] alive on ....., 19.... Death is said to have occurred on the date stated above, at 8:45 A.m.
The principal cause of death and related causes of importance were as follows:
Ruptured Gangrene appendix
Generalized Acute Peritonitis
Date of onset
Other contributory causes of importance: 121
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) Russell W. Kerr, M. D.
(Address) [illegible]

(Licensed Embalmer's Statement on Reverse Side)

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.

NAME, TIME, WITH UNFADING INK—THIS IS A PERMANENT RECORD

X14028

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 E W West

Licensed Embalmer No. 2710

P. O. Address 1905 Vine

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.