

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.

**JAN 13 1940**  
Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 Mo. & 11 days  
(Specify whether  
 In this community Ab. 40 Yrs.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1720 Prospect  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? --- years.

3. (a) PRINT FULL NAME Augustus Frederick Seeland 453  
 3. (b) If veteran, name was No  
 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Marr.  
 6. (b) Name of husband or wife Mrs. Sarah E. Seeland 6. (c) Age of husband or wife if alive 60 years  
 7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years 66 Months -- Days -- If less than one day br. min.

9. Birthplace Grand Rapids Michigan  
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter & Builder

11. Industry or business ---

MOTHER FATHER { 12. Name Edward Augustus Seeland  
 13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
 14. Maiden name Anna Barbara Slack  
 15. Birthplace Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Sarah E. Seeland  
 (b) Address 1720 Prospect Avenue

17. (a) Burial (b) Date thereof Jan. 2, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director A. W. Newsome, Sr.  
 (b) Address 1401 Brush Creek Blvd.

19. (a) Dec. 31, 1939 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 28th  
 year 1939 hour 6 minute 15 P. M.

21. I hereby certify that I attended the deceased from 11-17-39  
 to 12-28-39, 1939, to 12-28-39, 1939;  
 that I last saw him alive on 12-28-39, 1939;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Niliary tuberculosis with fibrous caseous tuberculosis; Diabetes mellitus with Diabetic ulcer.

Due to 23

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
 Of operations See above  
 Of autopsy See above

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury

23. Signature P. H. De Lina, M.D. (M. D. or other)  
 Address Supt. K.C. Gen. Hospital Date signed 12-29-39

Duration  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically.

JAN 30 1958

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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. *Emile M. Cap*

P. O. Address *(3506) K. e.*

**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.**