

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH ✓

State File No. 11176

Registration District No. 395

Primary Registration District No. 4232

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Blue Springs
 (If outside the city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Swine War. Hosp. of
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____ years, months or days) 74 yrs - 11 - 0

3. (a) PRINT FULL NAME J. D. Selvey 410

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FM 5. Color or race W
Sarah

6. (b) Name of husband or wife _____ 6. (a) Single, widowed, married, divorced Divorced

7. Birth date of deceased: April 13 - 1866
 (Month) (Day) (Year)

8. AGE: Years 74 Months 11 Days 0
 If less than one day _____ hr. _____ min.

9. Birthplace: Jackson Co Mo _____
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name John Selvey

13. Birthplace Va
 (City, town, or county) (State or foreign country)

14. Maiden name Crawford

15. Birthplace Va
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John W Adams

(b) Address Blue Springs Mo

17. (a) Buried (b) Date thereof 3-15-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Springs

18. (a) Signature of funeral director RS Webb

(b) Address Blue Springs

19. (a) April 11, 1940 (b) Mrs Thomas Portwood
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 13
 year 40 hour 4:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from Feb 10
 1940, to March 13, 1940;
 that I last saw him alive on March 13th, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death: Prostatitis, Chron

Due to Cystitis, Chron 37

Due to Senile degeneration

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy _____

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? _____

(Specify type of place) _____
 While at work _____ (e) Means of injury _____

23. Signature M G Rowe (M. D. or other) _____
 Address Blue Springs Mo Date signed 3-14-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

R. Burt

Licensed Embalmer No. 2353

P. O. Address.....

Blue Spring

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11176

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 395

Primary Registration District No. 4272

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Blue Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

John D. Silvey

(b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced Dev
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 11 0 hr. min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) April 11, 1943 (b) Mrs. Thomas Patwood
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 13
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____ (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 M. G. Rowe (M. D. or other) _____

Address Blue Springs _____ (City or town) _____ (State)

SUPPLEMENTAL

1940
S-11176