

JUN 14 1940  
Registration District No. **6114B**

Primary Registration District No. **6114B**

Registrar's No. **11**

1. PLACE OF DEATH:

(a) County Sullivan Penn. Towns  
(b) City or town Rural  
(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) 2/  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan  
(c) City or town Rural Penn Townshp  
(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 Rosa Belle Seward 630

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife John Seward 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 21 1865  
(Month) (Day) (Year)

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

9. Birthplace Don't know Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business On Farm

12. Name Charles Brookbanks

13. Birthplace Don't know Indiana  
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant Jay Seward  
(b) Address Green Castle Mo

17. (a) Burial (b) Date thereon April 22 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Castle

18. (a) Signature of funeral director W. E. Kent & Son

(b) Address Green City, Mo.

19. (a) May 31-40 (b) Virginia Gibson  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 21  
year 1940 hour 5:00 minute A M.

21. I hereby certify that I attended the deceased from MAR 15, 1940, to APRIL 21, 1940  
that I last saw her alive on APRIL 11, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death CARCINOMA - OF LIVER  
PANCREAS

Duration

2 years

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? 771

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

23. Signature W. E. Kent & Son (M. D. or other) 3

Address Green City Mo Date signed 4-22-40

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

46

RECEIVED

District Health Officer No. 10.

District File Number 6-40-1122

Date Filed JUN 6 1940

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.

Not Embalmed

Signed Glenn E. Kent

Licensed Embalmer No. 1769

P. O. Address Green City, Mo.

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. **1976 1**  
Registrar's No. **11**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **849**

Primary Registration District No. **6114 B**

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

**1. PLACE OF DEATH:**  
 (a) County **Sullivan**  
 (b) City or town **Penn Twp**  
(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 \_\_\_\_\_  
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** **Rose Belle Seward**  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **apr** day **21**  
 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

**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.

7. Birth date of deceased: (Month) (Day) (Year)  
**8. AGE:** Years **74** Months **8** Days **0** If less than one day \_\_\_\_\_ h. \_\_\_\_\_ min.

Immediate cause of death **Carcinoma of liver + pancreas**  
 Due to **Carcinoma of liver + pancreas**  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
 10. Usual occupation \_\_\_\_\_

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

**MOTHER FATHER**  
 11. Industry or business \_\_\_\_\_  
 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)

**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.  
**46**

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
 17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_  
 18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
 19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

**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? \_\_\_\_\_ Means of injury \_\_\_\_\_  
**23. Signature** **H. E. Schure** (M. D. or other) \_\_\_\_\_  
 Address **Green City Mo.** Date signed \_\_\_\_\_

SUPPLEMENTAL

