FILED JUL 22 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21084

Registration District No. 26 Primary Registration District No. 3002 Registrar's No. 88

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

1. PLACE OF DEATH:
(a) County Andrain County Hospital
(b) City or town Mexico, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Andrain County County
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone
(c) City or town Centralia 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.

3. (a) PRINT FULL NAME Walter Lee Sewell 401
3. (b) If veteran, name war
3. (c) Social Security No. 498-05-6986
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Goldie Sewell
6. (c) Age of husband or wife if alive 31 years
7. Birth date of deceased Oct (Month) 10 (Day) 1906 (Year)

8. AGE: Years 33 Months 9 Days 0 If less than one day hr. min.

9. Birthplace Centralia (City, town, or county) MO (State or foreign country)
10. Usual occupation Carpenter helper
11. Industry or business
FATHER
12. Name John Sewell
13. Birthplace Monroe Co. Mo. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Clara Tella Robbins
15. Birthplace Andrain Co. Mo. (City, town, or county) (State or foreign country)
16. (a) Informant John Sewell
(b) Address Mexico MO
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Centralia Mo. Cem
18. (a) Signature of funeral director M. McDonald
(b) Address Centralia Mo
19. (a) 7/10-1940 (Date received local registrar) (b) Blanche Neely (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day July year 1940 hour 10 minute 00 M.
21. I hereby certify that I attended the deceased from July 8, 1940 to July 10, 1940 that I last saw him alive on July 10, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Infection of gall bladder	
Due to: acute intestinal infection	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Paul E. Coil

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Paul E. Coil (M. D.) 1
Address Mexico Mo Date signed 7-10-40

(Licensed Embalmer's Statement on Reverse Side)

177 APR 8 1942

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 M. J. McDonald

Licensed Embalmer No. 2589

P. O. Address Centralia M

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

If this body is not embalmed, fact should be so stated above.

No. 2B
2-21-40
I X22659

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

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21084

Registration District No. 26 — Primary Registration District No. 3002 — Registrar's No. 88

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County: Andrain
(b) City or town: Mepico Mo.
(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 years, months or days)
In this community

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: Walter Lee Sewell
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
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 33 Months 9 Days 0 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 10 year 1940 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: Infection gall bladder — Duration: 2
Due to: acute intestinal infection — 1 week
Due to: "Rocky Mountain fever" 11
Other conditions: no gall stones.
(Include pregnancy within 3 months of death)

Major findings:
Of operations: 4 C
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: Paul E. Cox (M. D. or other)
Address: Mepico Mo. Date signed