

WED JUL 15 1940

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

22694
Do not use this space.

1. PLACE OF DEATH

(a) County *St. Clair* Registration District No. *761*
(b) Township _____ Primary Registration District No. *4456* Registered No. *20*
(c) City *Appleton City* (d) Street No. *Collett Hospital* 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

(a) Residence, No. *Rural - Henry Co. Mo.* St. (If nonresident, give city or town and State)
PINKIE ELIZABETH SEATON

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 6, 1920*

7. AGE YEARS *19* MONTHS *8* DAYS *7* If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Student*
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) *Clinton mo Henry Co.*

FATHER 13. NAME *Clarence W. Seaton*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Clinton Henry Co.*

MOTHER 15. MAIDEN NAME *Ethel Correll*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Clinton mo Henry Co.*

17. INFORMANT (ADDRESS) *Clarence W. Seaton Clinton, Mo. 6724*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Hickory Grove, Clinton* DATE *June 11, 1940*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *W. H. Clausant Clinton, Mo.*

20. FILED *June 9, 1940* *Oles Abrey* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *June 9, 1940*

22. I HEREBY CERTIFY, That I attended deceased from *May 21*, 19*40* to *June 9*, 19*40*
I last saw her alive on *June 9*, 19*40* Death is said to have occurred on the date stated above, at *7:15* a.m.
The principal cause of death and related causes of importance were as follows:

Septicemia, Streptococcus
Vindan

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? *No*

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? *No*
If so, specify _____
(Signed) *W. H. Clausant*, M. D.
836 (Address) *Appleton City, Mo*

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.

26

18
1940 6-9
1920 10-6

19-8-3

RECEIVED

District Health Officer No: 71

District Health Officer No: 7-40-1007

Date: 7-9-40

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,

on the 9th day of June 1940

or by

Registered Apprentice No., working under my personal supervision.

Signed *V. H. Linsant*

Licensed Embalmer No. 3779

P. O. Address *Clinton, 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. 22694
Registrar's No. 20

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:
(a) County St. Clair
(b) City or town Appleton City
(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.....
In this community..... (Specify whether years, months or days)

3. (a) PRINT FULL NAME Pinkie E. Featon
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S
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 19 Months Days If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name..... (City, town, or county) (State or foreign country)

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)..... (b)..... (Date received local registrar) (Registrar's signature)

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.

20. DATE OF DEATH: Month June day 9 year..... 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 Septicemia
Due to Septicemia
Endocarditis

Other conditions..... (Include pregnancy within 3 months of death) 9/19

Major findings of operations Not done
Of autopsy trauma

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?

23. Signature [Signature] (M. O. or No.)
Address..... Date signed.....

SUPPLEMENTARY

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

u-c

