

SEP 10 1940

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

28695
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 390

(b) Township Union Primary Registration District No. 5345 Registered No. 18

(c) City _____ (d) Street No. _____ 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 Patty Gals Seeggs 250

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-19-1939

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>9</u>	<u>10</u>	<u>15</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant

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) Memphis, Tennessee

FATHER

13. NAME James Seeggs

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Memphis, Tennessee

MOTHER

15. MAIDEN NAME Jella Miller

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Memphis, Tennessee

17. INFORMANT (ADDRESS) J. E. Miller, Memphis, Tenn

18. BURIAL, CREMATION, OR REMOVAL PLACE Meador Cem. DATE 9-5-1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) T. J. Dierker, 1360 B. B. Dierker, Memphis, Tenn

20. FILED 9-6-40 B. B. Dierker Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-4-1940

22. I HEREBY CERTIFY, That I attended deceased from 7-3-1940, to 7-4-1940, 1940

I last saw her alive on 7-4-1940, 1940. Death is said to have occurred on the date stated above, at 10 P.M.

The principal cause of death and related causes of importance were as follows:

Septicemia

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 1940

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? _____

If so, specify _____

(Signed) W. G. Giles M. D.
(Address) Memphis, Tenn

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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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

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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.....

P. O. Address.....

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. 28695-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 396

Primary Registration District No. 53745-

Registrar's No.

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

1. PLACE OF DEATH:

(a) County. Iron
(b) City or town. Union
(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.
In this community. (Specify whether years, months or days)

3. (a) PRINT FULL NAME. Patty Hale Sengge

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. Inf.

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
9 15 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) (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)

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 7 day 4 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 and that death occurred on the date and hour stated above. Immediate cause of death. Sepsis

Due to. Duration

Due to. Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations. Of autopsy.

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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) (e) Means of injury.

23. Signature. T. C. Giles (M. D. or other) Address. Date signed 10-30-40

SUPPLEMENTAL COPY

- Information from letter -

Blood poisoning caused by a
blood boil on leg between knee
and ankle. #