No. 2
-10-39
RECEIVED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30870

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 3433

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C.General Hospital,K.C.Mo. (If not in hospital or institution, write street number or location) 1

(d) Length of stay: In hospital or institution 1 Mo. & 20 days (Specify whether 25 Yrs.

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town JKansas City (If outside city or town limits write "RURAL") 0

(d) Street No. 2640 Montgall Avenue (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME ARTHUR SELLARS

3. (b) If veteran, name war None

3. (c) Social Security No. None 494-12-8868

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Laura Sellers

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased December (Month) 5 (Day) 1880 (Year)

8. AGE: Years 59 Months 8 Days 26 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Texas (State or foreign country) 1

10. Usual occupation Laborer 9

11. Industry or business Same 9

FATHER
12. Name Henry Sellers
13. Birthplace Unknown (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name Alace Saggs
15. Birthplace Unknown (City, town, or county) ..... (State or foreign country)

16. (a) Informant Mr. Bill Sellers

(b) Address 3034 Whitters St. Louis Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept (Month) 3 (Day) 1940 (Year)

(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director Rose & Henderson

(b) Address 4139 E. 15th St. K.C.Mo.

19. (a) Sept. 2 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 31st year 1940 hour 5 minute 20 A. M.

21. I hereby certify that I attended the deceased from 7-11-40, 19..., to 8-31-40, 19...; that I last saw him alive on 8-31-40, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of esophagus with esophago-tracheal fistula

Due to .....

Due to 4b

Other conditions Pulmonary abscesses (Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy See above

Duration

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 1

23. Signature Drury R. Thom (M. D. or other) .....

Address Med.Dir.K.C.Gen.Hospital Date signed .....

(Licensed Embalmer's Statement on Reverse Side)

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 G. E. Henderson

Licensed Embalmer No. 3657

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.