

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31077**
Registrar's No. **3640**

Registration District No. **399**

Primary Registration District No. **1002**

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 No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Mo. & 10 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** Barton
(c) City or town **Kansas City** Nevada, Mo.
(If outside city or town limit, write "RURAL")
(d) Street No. **1027 1/2 Pennings**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME **GEORGE B. SEEHORN**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Clara** 6. (c) Age of husband or wife if alive **69** years
7. Birth date of deceased **February 1 1863**
(Month) (Day) (Year)

8. AGE: Years **77** Months **7** Days **16** If less than one day
_____ hr. _____ min.

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

10. Usual occupation **Farming**

11. Industry or business _____

12. Name **Reuben Seehorn**

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

14. Maiden name **Emma Brown**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. James F. Boyd**

(b) Address **Nevada Mo.**

17. (a) **Burial** (b) Date thereof **Sept. 19 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Nevada, Missouri**

18. (a) Signature of funeral director **Shrag & McClure**

(b) Address **N. Mo.**

19. (a) **Sept. 17, 1940** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** **17th**
year **1940** hour **7:00 A.M.** minute _____ M.

21. I hereby certify that I attended the deceased from **July 7th**, 19**40**, to **Sept. 17th**, 19**40**,

that I last saw him alive on **Sept. 17th** 19**40** and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of the bladder**

Due to _____
Due to **51**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **None**

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?

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

23. Signature **Dr. K.C. Gen. Hospital** (M. D. or other) **9-17-40**
Address **Med. Dir. K.C. Gen. Hospital, K.C. Mo.** Date signed

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

MOTHER FATHER

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 the above constitutes grounds for revocation of license.)

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