

No. 2
-17-39
X23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33330**
Registrar's No. **12**

Registration District No. **2947**

Primary Registration District No. **4574**

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

1. PLACE OF DEATH: **Sullivan**
 (a) County **Sullivan**
 (b) City or town **Green Castle**
 (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 **20**
 (Specify whether
 in this community **Life**
 years, months or days)

3. (a) PRINT FULL NAME **Cassinda Seward**
 3. (b) If veteran, name war **✓**
 3. (c) Social Security No. **✓**

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Jan 9 1855**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	85	7	22	hr. _____ min. _____

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

10. Usual occupation **Housekeeper**

11. Industry or business _____

12. Name **W. J. Seward**
 13. Birthplace **Ky**
 (City, town, or county) (State or foreign country)

14. Maiden name **Ellen Jones**
 15. Birthplace **Ill**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Jay Seward**
 (b) Address **Green Castle, Mo.**

17. (a) **Burial** (b) Date thereof **9-1-1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Castle, Mo.**

18. (a) Signature of funeral director **Glen E. Kent**
 (b) Address **Green City, Mo.**

19. (a) **Oct 1-1940** (b) **Virginia Gibson**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Sull.**
 (c) City or town **Green Castle**
 (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.? **12** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUGUST** day **31st**
 year **1940** hour **3:00** minute **P.**-M.
 21. I hereby certify that I attended the deceased from **Jan 1**
 19**40** to **AUGUST 31**, 19**40**
 that I last saw her alive on **AUGUST 10**, 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death **VALVULAR HEART DISEASE.**
 Duration _____
 Due to **✓**
 Due to **✓** **92 in**
 Other conditions _____
 (Include pregnancy within 3 months of death)

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?
771
 While at work? **✓** (Specify type of place) (e) Means of injury _____
 23. Signature **J. B. Schur** (M. Doer other) **1**
 Address **Green City** Date signed **8-31-40**

RECEIVED

District Health Officer No. 10

District File Number 10-40-1866

Date Filed OCT 8 1940

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green City 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, fact should be so stated above.