

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38011**

Registration District No. **17**

Primary Registration District No. **4011**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County **Atchison**
 (b) City or town **Fairfax**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Allison Residence of Fairfax
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community **Was not a Resident of** (Specify whether) **3**
 years, months or days **Fairfax** **3**

3. (a) PRINT FULL NAME **Lawrence Oren T Seitz**
 3. (b) If veteran, name war **No** 3. (c) Social Security No. **770**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, divorced, married **single**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Sept. 8, 1919**
 (Month) (Day) (Year)

8. AGE: Years **21** Months **2** Days **18** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Trucker**
Hauling stock to Market

11. Industry or business _____
 12. Name **Cletus Seitz**
 13. Birthplace **Missouri**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Tracy or Andes**
Virginia
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant **Miss Cletus Seitz**
 (b) Address **Maitland, Missouri**

17. (a) **Burial** (b) Date thereof **Nov. 29, 1940**
 (Burial, cremation, or removal) **Maitland** (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director **W. C. Crawford**
 (b) Address **Maitland, Mo.**

19. (a) **Nov. 28, 1940** (b) **Leta B. Black**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Holt**
 (c) City or town **Near Maitland Rural**
 (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.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Nov** day **26**
 year **1940** hour **10.30** minute _____ P. 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 **Poisoning by Strychnine** Duration **45**
 Due to **Taking of Strychnine** Min
 Due to _____

Other conditions (Include pregnancy within 3 months of death) **16 3**
 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) **Suicide**
 (b) Date of occurrence **November, 26th, 1940**
 (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?
Took poison #11 seated in truck on streets of Fairfax
 While at work? **15** (Specify type of place) (Specify means of injury) **Fairfax**
 23. Signature **W. C. Crawford** (Specify name of coroner or other) **5**
 Address **Westboro, Missouri** Date signed **Nov 27th**

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 with the above constitutes grounds for revocation of license.)

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