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-13-40  
-17-39  
X 23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED JUN 25 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

16354

State File No.

791

1003

Registration District No.

Primary Registration District No.

Registrar's No.

3872

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Anthony's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3.e(a) PRINT FULL NAME Florence Elizabeth Seward

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife J. Frederick Seward 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased Jan. 25th 1891  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
50 4 11 hr. min.

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name W.R. McFarland

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

14. Maiden name Mabel Witherspoon

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

16. (a) Informant J. Frederick Seward

(b) Address 5340 Murdoch Ave.

17. (a) Burial (b) Date thereof 5-8th 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Kriegshauser Mortuaries

(b) Address 4228 So. Kingshighway Blvd.

19. (a) MAY 7 1941 (b) J. W. Brewster  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5340 Murdoch Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6th  
year 1941 hour 5 minute A.M. M.

21. I hereby certify that I attended the deceased from 4/12/41  
1941, to May 6, 1941;  
that I last saw her alive on May 5, 1941,  
and that death occurred on the date and hour stated above.

Immediate cause of death Post operative  
fulminating thyroidectomy

Due to Toxic Adenoma

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: Toxic Goiter  
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 9

23. Signature Robert G. Warner (M. D. or other)  
Address Paul Brown Bldg Date signed May 7-41

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

MOTHER FATHER

Paul Brown Bldg.  
10-1  
Ch: 4747

**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 *Ernie M. Hermans*

Licensed Embalmer No. 3024

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, fact should be so stated above.**