

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 123

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbiana
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Boone Co. Hosp. O.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Hosp. 1 day
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME Clarence Alfred Seuf

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced D

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

7. Birth date of deceased Dec 24 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 4 13 hr. min.

9. Birthplace Centralia MO O
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

MOTHER { 12. Name Derman C Seuf

13. Birthplace Centralia MO O
(City, town, or county) (State or foreign country)

14. Maiden name Fern G. Stueber

15. Birthplace Centralia MO O
(City, town, or county) (State or foreign country)

16. (a) Informant Leona Seuf

(b) Address 5807 Plymouth St. St. Louis

17. (a) Removal (b) Date thereof 2-8-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia Mo

18. (a) Signature of funeral director M. J. Madame

(b) Address Centralia Mo.

19. (a) 7-9-1941 (b) Allie Selby
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Centralia (b) County Boone
MO
(c) City or town 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.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7th
year 1941 hour 12 minute 55 p M.

21. I hereby certify that I attended the deceased from 5-6-41
_____, 19____, to 5-7-41, 19____;
that I last saw him alive on 5-7-41, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Pneumococcus type VI meningitis</u>	<u>4 days</u>
Due to <u>Pneumonia type VI</u>	<u>?</u>
Due to _____	_____

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? 74

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature J. N. Dix (M. D. or other) MD
Address Boone Co. Hosp. Date signed 5-7-41

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

10
2
4

109

15

BYVCK

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

M J McWaid

Licensed Embalmer No. 2589

P. O. Address Quebec, N.S.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19499

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(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 _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Clarence Alfred Smith
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 8

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one year
1 4 13 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7
year 1941 hour _____ minute _____ 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) Pneumonia Duration _____

Type II meningitis

Due to Pneumonia Type II

Due to Lobar Pneumonia

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? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

19499