No. 2
11-10-39
5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

AUG 11 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25692

Registration District No. 603 Primary Registration District No. 5799 Registrar's No.

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

1. PLACE OF DEATH:
(a) County New Madrid.
(b) City or town Mile South of Marshouse
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: No, Wide Twp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No (Specify whether years, months or days)
In this community all of Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid 72
(c) City or town Rural
(If outside city or town limits write "RURAL")
(d) Street No. Near Marshouse.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME SAMUEL SEALS
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex M
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 Feb (Month) 9 (Day) 1910 (Year)

8. AGE: Years 31 Months 5 Days 22 If less than one day hr. min.

9. Birthplace New Madrid Co (City, town, or county) Mo. (State or foreign country)
10. Usual occupation no
11. Industry or business no
12. Name Charles Seals
13. Birthplace Steele (City, town, or county) Mo (State or foreign country)
14. Maiden name Lillie Walker
15. Birthplace Belleville. Ill. (City, town, or county) (State or foreign country)
16. (a) Informant Celip Ellis
(b) Address Marshouse, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2-1941 (Month) (Day) (Year)
(c) Place: burial or cremation Sikeston
18. (a) Signature of funeral director Richards and C
(b) Address New Madrid
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31 year 1941 hour 11:30 minute P.M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Was hit by car while walking on New Madrid Co. road near Marshouse. Crushed head, large cut above left eye, cut in center of head, Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations No

Of autopsy No

Duration

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) Accident 072.
(b) Date of occurrence July 31-1941
(c) Where did injury occur? Near Marshouse New Madrid Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place New Madrid Co road (Specify type of place)
While at work? (e) Means of injury
23. Signature Lee Hedgpeth Deputy Coroner (M. D. or other)
Address New Madrid. Date July 1-1941

(Licensed Embalmer's Statement on Reverse Side)

AUG 5 1941

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 Leo H. Lynneth

Licensed Embalmer No. 5803

P. O. Address New Modwell

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.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25692

Registration District No. 603 Primary Registration District No. 5799 Registrar's No. 7

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town ..... (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 years, months or days) In this community .....

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 .....

3. (a) PRINT FULL NAME Samuel Seals

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 S

6. (b) Name of husband or wife .....

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

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

8. AGE: Years | Months | Days | If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

12. Name .....

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

14. Maiden name .....

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

16. (a) Informant .....

(b) Address .....

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

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address .....

19. (a) 9. 18. 1941 (Date received local registrar) (b) Mrs John Pearcy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3 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 ..... Duration

Due to .....

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

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

Address ..... Date signed .....

SUPPLEMENTARY