

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

FILLED OCT 24 1941

32701

1. PLACE OF DEATH  
 County Scotland County Registration District No. 810  
 Township W. Jefferson Primary Registration District No. 4488  
 City Marion (No. 1) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 Registered No. 32

2. FULL NAME Florence Elizabeth Seedham  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

5A. IF MARRIED, WIDOWED, OR DIVORCED—  
 HUSBAND OF (OR) WIFE OF B. H. Seedham

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 17, 1864

7. AGE: YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
77 5 26 \_\_\_\_\_

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work House wife  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 13 1941  
 17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1941, to Sept 13, 1941  
 that I last saw him alive on Sept 13, 1941, and that death occurred, on the date stated above, at 7 A. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral hemorrhage  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) Ann Bethler, M. D.  
9-13-1941 (Address) Memphis, Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

9. BIRTHPLACE (CITY OR TOWN) W. Pleasant  
 (STATE OR COUNTRY) Iowa

10. NAME OF FATHER Robert R. Pleasant

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Elice Toll

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Ky

14. INFORMANT Miss Art Niblett  
 (Address) Memphis, Mo.

15. FILED Oct 3 1941 E. E. Parish  
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL W. Pleasant, Iowa DATE OF BURIAL 9/15/1941  
 20. UNDERTAKER W. W. Payne & Sons ADDRESS Memphis

RECEIVED

District Health Officer No. 10

District File Number 10-41-1875

Date Filed OCT. 17 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 32701  
Registrar's No. \_\_\_\_\_

Registration District No. 810

Primary Registration District No. 4488

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

1. PLACE OF DEATH:

(a) County Scotland  
(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  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Filmece E. Leedham

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

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

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

7. Birth date of deceased Mar 17, 1864  
(Month) (Day) (Year)

8. AGE: Years 77 Months 5 Days 26  
(If less than one day \_\_\_\_\_ min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry of 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) \_\_\_\_\_ (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) Oct 3 - 1941 (b) E. E. Tarrish  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scotland  
(c) City or town Memphis  
(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 Sept day \_\_\_\_\_  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) \_\_\_\_\_

(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 \_\_\_\_\_

SUPPLEMENTARY

*Handwritten scribbles and illegible text at the top of the page.*

*Faded, mostly illegible typed text on the left side of the page.*

*Faded, mostly illegible typed text on the right side of the page.*