

FILED NOV 9 1942
320

Registration District No. _____

Primary Registration District No. **080**

Registrar's No. _____

1. PLACE OF DEATH
(a) County **St. Genevieve**
(b) City or town **Farmington, R.F. 3-Suburban**
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **three months** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **mo** (b) County **St. Genevieve**
(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 **Virgil Homer Seel**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct** day **8th** year **1942** hour **1** minute **45.2** A.M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Edith Thompson Seel** 6. (c) Age of husband or wife if alive **37** years
7. Birth date of deceased **Sept 13 1904** (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **July 12** 1942 to **Oct 8th** 1942
that I last saw him alive on **Oct 1** 1942 and that death occurred on the date and hour stated above.

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

Immediate cause of death **Pulmonary Tuberculosis and Edema - Cardiac** Duration **6 mo.**

9. Birthplace **Bonne Terre St. Francois Co. MO** (City, town, or county) (State or foreign country)

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy **no**

10. Usual occupation **Truck Driver**

11. Industry or business _____
12. Name **Luther Melvin Seel**
13. Birthplace **St. Genevieve Co. MO** (City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

14. Maiden name **Lucas White**
15. Birthplace **Potomac Washington Co. MD** (City, town, or county) (State or foreign country)

16. (a) Informant **Burford Bartore**
(b) Address **Esther MO**

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? _____

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Oct 9-42** (Month) (Day) (Year)
(c) Place: burial or cremation **Littlevine St. Genevieve Co. MO**
18. (a) Signature of funeral director **Dean General Holmes**
(b) Address **Farmington MO**
19. (a) **Oct 12 1942** (Date received by Registrar) (b) **Rev Joseph H. Garner** (Registrar's signature)

While at work _____ (Specify type of place) (Means of injury) _____
23. Signature **L. M. Stanfield** (M. D. or other) _____
Address **Farmington MO** Date signed **10/8/42**

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

95
0
0

NOV 9 1942

RECEIVED

District Health Officer (b) *Call*

District File Number *10-11*

Date Filed *10-4-42*

RECEIVED

District Health Officer No.

District File Number *1142-13*

Date Filed *10-7-42*

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

me

Registered Apprentice No.

working under my personal supervision.

Signed

W. Hozean

Licensed Embalmer No.

4084

P. O. Address

Farmington, Me

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34947

Registration District No. 320

Primary Registration District No. 6080

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St Genevieve
(b) City or town Rural
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St Genevieve
(c) City or town Farmington (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) Route # 4.
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Vigil Homer Seal
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 _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 13
(Month) (Day) (Year)

8. AGE: Years 38 Months 20 Days 13
(If less than one day _____ min)

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

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) _____ (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 12 - 42 (b) Rev Joseph A. Kanner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day _____
year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Subepilepsia and l. mas.
Endocarditis
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 _____

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

Address _____ Date signed _____

SUPPLEMENTARY

1942

S-34947