S. No. 2
M—2-43
5-17-39
X3569

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

...RTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 13 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

13787

State File No.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 467

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 623 1/2 So 8th
(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 Missouri (b) County Buchanan

(c) City or town St Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 623 1/2 So 8th
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME David G. Seright

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Male

5. Color or race White

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 Jan (Month) 30 (Day) 1864 (Year)

8. AGE: Years 79 Months 2 Days 25 If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name Unknown
13. Birthplace ✓ (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ✓ (City, town, or county) 9 (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-1-43 (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director [illegible]
(b) Address 1946 Colhaus St.

19. (a) 5-1-43 (Date received local registrar) (b) Rose Heggy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29th year 1943, hour 3 minute 15 P M.

21. I hereby certify that I ~~attended~~ viewed the deceased ~~from~~ on April 29th, 1943, to ....., 19....; that I last saw h..... alive on ....., 19....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Thrombosis	1 day
Due to Chronic Myo-Carditis	5 yrs
Due to Man was found dead in bed in his room He lived alone and probably died three or four days before the body was found	93 d

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operation .....
Of autopsy No

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 H F Mundy (M.D. or other) Coroner

Address 404 So 3d St St Joseph, Mo Date signed 4/29/43

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Not Embalmed ....., Registered Apprentice No. .....,

working under my personal supervision.

Signed Robert L Yapla

Licensed Embalmer No. 3308

P. O. Address St Joseph Mo.

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.

. S. No. 2B
—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

Try April

State File No.

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(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 (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 David G Seright

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 md

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

7. Birth date of deceased Jan 30 - 1864
(Month) (Day) (Year)

8. AGE: Years 79 Months 2 Days 29 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant not stated. Man
(b) Address was dead 4 days before

17. (a) found (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute 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.

	Duration
Immediate cause of death	
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

S-13787