

FILED JAN 12 1944

Registration District No. 224

Primary Registration District No. 6093

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
R.F.D. I  
(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 42 Years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline

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

(d) Street No. R.F.D. I  
(If rural, give location)

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

3. (a) PRINT FULL NAME Mrs. Clara Seat

3. (b) If veteran, name war # \_\_\_\_\_

3. (c) Social Security No. # \_\_\_\_\_

4. Sex Female / Color or race White

5. Female / White

6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife H.L. Seat

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

7. Birth date of deceased May 25 1866  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>7</u>	<u>6</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name William Ray

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

14. Maiden name Malissa Grissom

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

16. (a) Informant Mrs. Fisher Lacy

(b) Address Marshall, Mo.

17. (a) Burial (b) Date thereof Jan. 2, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ridge Park Cemetery

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

(b) Address \_\_\_\_\_

19. (a) 1-1-1944 (b) Thos. O. Westbrook  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 31  
year 43 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from Dec 31, 1943, to Dec 31, 1943  
that I last saw her alive on 11 30, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cardio Renal

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

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

Other conditions (Include pregnancy within 3 months of death): Influenza

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

Duration 6 hrs

PHYSICIAN Stacy

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 1/1/44

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

RECEIVED

District Health Officer No 8,

District File Number

Date Filed

1-10-44

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. 8,  
working under my personal supervision.

Signed J. Leslie Surrency

Licensed Embalmer No. 3235

P. O. Address Marshall, Va.

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.