

FILED MAY 20 1944 318

Registration District No.

Primary Registration District No.

1003

4423

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Barnes Hospital  
(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 Seth Carl French

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Fay French 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased March 28 1897  
(Month) (Day) (Year)

8. AGE: Years 47 Months 1 Days 14  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Mechanic

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

MOTHER FATHER  
12. Name Sherman French  
13. Birthplace Sullivan Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Edith Layton  
15. Birthplace Sullivan Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ray Doolin  
(b) Address Sullivan, Ill.

17. (a) Removal (b) Date thereof 5-13-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sullivan, Illinois

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Blvd.

19. (a) MAY 1 1944 (b) J. F. Bradack  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Effingham  
(c) City or town Effingham  
(If outside city or town limits, write "RURAL") UNR.  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 2.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12  
year 1944 hour 3:30 minute A. 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 Cancer of sigmoid with Metastases to Liver Duration \_\_\_\_\_  
Metformin the Result of Natural Cause. An Accidental could not be determined.  
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) Open Verdict  
(b) Date of occurrence Unknown  
(c) Where did injury occur? Unknown  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Unknown  
While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury 3

23. Signature Thomas F. Allen (M. D. or other)  
Address Deputy Coroner Date signed 5-12-44

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

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**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 *John Gonski*  
Licensed Embalmer No. *3398*

P. O. Address.....

**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.**