

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 19 1944

Registration District No. 16

Primary Registration District No. 386-06075

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. State Hospital No. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 yrs. 4 mos. 19
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
(c) City or town Bonne Terre
(If outside city or town limits, write "RURAL")
(d) Street No. Route #1
das. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME DAVE SEALS (WILLIAM DAVID SEEL)

3. (b) If veteran, name war Unknown
3. (c) Social Security No. 489-18-7790

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

6. (b) Name of husband or wife Lilly Miller
6. (c) Age of husband or wife if alive Age Unknown

7. Birth date of deceased October 19, 1880
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>63</u>	<u>7</u>	<u>6</u>	hr. min.

9. Birthplace Ste. Genevieve Co., Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Mining

11. Industry or business _____

12. Name James Seel

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

14. Maiden name Julia Ann Seel

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

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 5-28-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marvin Chapel Cem., Bonne Terre, Mo.

18. (a) Signature of funeral director Alvin Hood Undertaking Co.

(b) Address Nlat River MO

19. (a) 6-7-44 (b) James Seel
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25,
year 1944 hour 9 minute 15 A. M.

21. I hereby certify that I attended the deceased from April 1, 1943 to May 25, 1944
that I last saw him alive on May 25, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Inoperable abdominal Ca Primarily in head of pancreas
Duration _____

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy No autopsy.

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?
Terre, Mo.
(Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) 2nd

Address 408 N. River Date signed 5-25-44

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

MOTHER FATHER

400

940

469

1373

(Licensed Embalmer's Statement on Reverse Side)

Farmington, Mo.

JUN 24 1944

RECEIVED

District Health Officer No. 4

File Number 640-3978

6-17-44

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.....
working under my personal supervision.

Signed... *Alvin W. Hood*

Licensed Embalmer No. 2780

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.