No. 2
—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 14 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35105
State File No.

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 208

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 110 1/2 Kirby 1
(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 Randolph
(c) City or town Moberly 99
(If outside city or town limits, write "RURAL")
(d) Street No. 110 1/2 Kirby 1
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0 0

3. (a) PRINT FULL NAME Mattie Seymour
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex Female 1
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 4th (Day) 1878 (Year)

8. AGE: Years 65 Months 7 Days 7 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation At home
11. Industry or business
FATHER 12. Name Peter Fleming
13. Birthplace (City, town, or county) Ky (State or foreign country)
MOTHER 14. Maiden name Frances Byrum
15. Birthplace (City, town, or county) Mo (State or foreign country)
16. (a) Informant Mrs. J. J. McGrath
(b) Address Moberly
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14th 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Sturgeon Mo
18. (a) Signature of funeral director Mahan and Son
(b) Address Moberly Mo
19. (a) 10-13-44 (Date received local registrar) (b) Irma Nave (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11th year 1944 hour 11 minute 20 P. M.
21. I hereby certify that I attended the deceased from April 11 1943 October 11 1943, to October 11 1944; that I last saw her alive on October 11 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Heart Disease
Hypertension
Due to Acid Nephritis
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration ✓

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 0
23. Signature M R Noland (M. D. or other) M D
Address Moberly Mo Date signed Oct 13 1944

1036

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 11-44-1848
Date Filed NOV 10 1944

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 Frank O. McNutt

Licensed Embalmer No. 3021

P. O. Address Moberly 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.

. No. 2B
M—5-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 208

1. PLACE OF DEATH

(a) County Randolph

(b) City or town Mabelly
(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 years, months or days)

In this community

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 Mattie Seymour

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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 Mar (Month) 4 (Day) 1878 (Year)

8. AGE: Years 65 Months 7 Days 7 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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
(b) Address

17. (a) (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 Oct day 11 year 1944 hour hr. 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 Heart disease	
Due to Hy sclerosis	
Due to and nephritis	
Due to Chronic nephritis	
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 R Koland (M. D. or other)
Address Moberly Mo Date signed 11-15-44

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

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

35105