

No. 2  
-5-43  
-17-39  
X36671

FILED DEC 18 1944  
Registration District No. **2044**

Primary Registration District No. **3056**

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

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:  
**Wabash 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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St Louis**

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

(d) Street No. **2010 Crittenden**  
(If rural, give location)

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

3. (a) PRINT FULL NAME **Orville Sellers**

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

3. (c) Social Security No. **702-05-8435**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **11<sup>th</sup>**  
year **1944** hour **8** minute **25** A.M.

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Bertha Sellers**

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

7. Birth date of deceased **Feb 13<sup>th</sup> 1885**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **September 1943** to **November 11 1944**  
that I last saw him alive on **November 11 1944**  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

**59** **8** **18** hr. \_\_\_\_\_ min.

Immediate cause of death: **Heart failure**

Due to **Pyelocystic cancer**

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation **Section man**

11. Industry or business **Wabash RR**

12. Name **John Sellers**

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

14. Maiden name **Hettie Metcalf**

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

16. (a) Informant **Mrs. Bertha Sellers**

(b) Address **St Louis, Mo**

17. (a) **Bemival** (b) Date thereof **Nov 12<sup>th</sup> 44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St Louis, Mo**

18. (a) Signature of funeral director **Mahan and Son**

(b) Address **Moberly Mo**

19. (a) **11-12-44** (b) **J. Haul**  
(Date received local registrar) (Registrar's signature)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury **⊙**

23. Signature **Eric Handley** (M. D. or other) \_\_\_\_\_

Address **Wabash Hospital Moberly Mo** Date signed **11-12-44**

DEC 27 1944

MAR 25 1948

RECEIVED

District Health Officer No. 10

District File Number 12-4-200

Date Filed DEC 14 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 B. Witt*

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. JAN Dec  
Registrar's No. 229

Registration District No. 294 Primary Registration District No. 3056

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:  
(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 Orville Sellers  
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 M

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

7. Birth date of deceased Feb. 13 (Month) (Day) (Year)

8. AGE: Years 59 Months 8 Days \_\_\_\_\_ (less than one day) min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

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

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov Day 14 Year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death Heart failure Duration \_\_\_\_\_

Due to Bronchogenic Cancer  
Primary sect cause of death

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

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

Of 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Eric Handler (M. D. or other) \_\_\_\_\_

Address Wabash Hospital Moberly Date signed 12-21-44

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

S-41995-1944