

FILED JAN 8 3 1945

Registration District No. 65

Primary Registration District No. 4534

1. PLACE OF DEATH:

(a) County Washington  
(b) City or town Lealdonia  
(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 1  
(Specify whether  
In this community 1  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Washington  
(c) City or town Lealdonia 110  
(If outside city or town limits, write "RURAL")  
(d) Street No. 110  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 19

3. (a) PRINT FULL NAME DELPHIA JANE SEABOURNE

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

4. Sex Female 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 8 years (Day) (Year) 1868

8. AGE: Years 76 Months 4 Days 7 If less than one day hr. min.

9. Birthplace Belgrade (City, town, or county) (State or foreign country) 11

10. Usual occupation Housewife

11. Industry or business house of sale

12. Name Leander Seabourne

13. Birthplace Lealdonia (City, town, or county) (State or foreign country) 9

14. Maiden name Delphia Seabourne

15. Birthplace Lealdonia (City, town, or county) (State or foreign country) 9

16. (a) Informant John George Seabourne

(b) Address Lealdonia

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 17 - 44 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director Thomas W. White Sons

(b) Address Lealdonia

19. (a) 12-20-44 (Date received local registrar) (b) Ella W. Tuttle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15 year 1944 hour 7 minute 30 M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... and that death occurred on the date and hour stated above.

Immediate cause of death cardiac insufficiency Duration 2 years

Due to Age, bronchial pneumonia

Due to.....

Other conditions (Include pregnancy within 3 months of death) 960

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) (e) Means of injury.....

23. Signature J. A. Humphrey (M., D. or other) 3

Address Polase Trip Date signed 12-16-44

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

10

VED

Health Officer No. 4  
District File Number 145-11  
Date Filed 1-5-45

**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 *Amel White*  
Licensed Embalmer No. *3412*  
P. O. Address *Smith Hill*

**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.**