

No. 4
-5-42
-17-39
X32873

State File No.

FILED DEC 7 1945
Registration District No. 248

Primary Registration District No. 4369

Registrar's No.

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Seneca
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 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 33 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton 73
(c) City or town _____
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Samuel Carl

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Vera Carl 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased May 21 - 1874
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 7
year 1945 hour 5 minute 30 L.M.

21. I hereby certify that I attended the deceased from 12:00 P.M. Nov 7, 1945 to 2:00 P.M. Nov 7, 1945
that I last saw him alive on Nov 7, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion
Due to Had hypertension

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations 94 w
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) _____
(e) Means of injury _____
23. Signature J. P. Seimeler (M. D. or other) _____
Address Seneca Mo Date signed 11-10-45

8. AGE: Years Months Days If less than one day
71 8 17 hr. min.

9. Birthplace Fort Scott Kans. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Hammer

11. Industry or business Abraham Carl

12. Name Abraham Carl

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

14. Maiden name Cordelia Morris

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

16. (a) Informant Mar. Vera Carl

(b) Address Seneca Mo.

17. (a) Burial (b) Date thereof Nov. 8 - 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Seneca Mo.

18. (a) Signature of funeral director Bill Ruppard

(b) Address Seneca Mo.
19. (a) 11-11-1945 (b) Nette Morris
(Date received local registrar) (Registrar's signature)

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

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.

RECEIVED DEC 6 1945

District Health Officer No.

District File Number ... 1145-215 ...

Date Filed ... DEC 6 1945 ...

Signed

B. M. Buzzard

Licensed Embalmer No. 2334

P. O. Address Seneca 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. DecRegistration District No. 248Primary Registration District No. 4869

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Seneca
(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 Samuel Carl

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 May 2
(Month) (Day) (Year)8. AGE: Years 71 Months _____ Days _____ (If less than one day) hr. _____ min.9. Birthplace Kansas
(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 MO (b) County Newton
(c) City or town Seneca
(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 _____
year 1945 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 _____

Duration

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 sta-
tistically.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

38044