

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

4420

State File No.

Registrar's No.

FILED FEB 15 1946

Registration District No.

Primary Registration District No.

6272

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Rural - Allen
(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 none
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME TERESA CASEY SEAT

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Lee Seat 6. (c) Age of husband or wife if alive 17 years
7. Birth date of deceased mar 17 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 8 20 hr. min.

9. Birthplace Calwell Co mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Thomas Baird
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Allen Cooper
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Wallace Seat
(b) Address Denver mo

17. (a) Burial (b) Date thereof Dec 9 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Hope Cemetery

18. (a) Signature of funeral director Bram Mos
(b) Address Denver mo

19. (a) Jan 6 1946 (b) Leta E. Dawson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Worth
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 7
year 1945 hour 6 minute 20 AM.

21. I hereby certify that I attended the deceased from Nov 1 1945 to Dec 7 1945
that I last saw him alive on Dec 7 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Hypertension
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 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 place of place) Means of injury
23. Signature Dr. Charles H. Williamson (M. D. or other)
Address Country mo Date signed 12-21-45

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

100344

345

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *J. P. Brann*

Licensed Embalmer No. *2947*

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.