

FILED MAR 15 1946
Registration District No. **354**

Primary Registration District No. **6194**

Registrar's No. _____

1. PLACE OF DEATH: **Texas**
 (a) County **Texas**
 (b) City or town **Rural Cash Imp**
 (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 **3 weeks**
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MO.** (b) County **TEXAS 107**
 (c) City or town **RURAL**
 (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 **HAL DEAN SEVEDGE**

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

4. Sex **Mo** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **50**

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

7. Birth date of deceased **Feb. 8, 1946**
 (Month) (Day) (Year)

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

9. Birthplace **Texas County, Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name **Alva Sevedge**

13. Birthplace **Texas County, Mo.**
 (City, town, or county) (State or foreign country)

14. Maiden name **Essie L. Midgett**

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

16. (a) Informant **Alva Sevedge**

(b) Address _____

17. (a) **Burial** (b) Date thereof **2/28/46**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Stults Cemetery**

18. (a) Signature of funeral director **None**

(b) Address _____

19. (a) **Mar 16, 1946** (b) **J. Cunningham**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **28**
 year **1946** hour **4 am** minute **---** M.

21. I hereby certify that I attended the deceased from **Feb. 27**, 19**46**, to **Feb. 28**, 19**46**
 that I last saw him alive on **Feb. 27**, 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Malnutrition** Duration **3 wks**

Due to **improper feeding** **3 wks**

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings:
 Of operations _____
 Of autopsy **158**

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 **2**

23. Signature **Thomas T. Francis** (M. D. or other) **D.O.**

Address **Willow Springs Mo** Date signed **28/2/46**

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

MOTHER FATHER

RECEIVED

District Health Officer No- 5,

District File Number 346201

Date Filed 3, 14, 46

OSSEAX 10
SECRET

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.

Not embalmed
Signed.....
Licensed Embalmer No.....
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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Mar

Registration District No. 33-4

Primary Registration District No. 6198

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Jeffer
(b) City or town Rural
(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 3 weeks
years, months or days

3. (a) PRINT FULL NAME Hal D. Sevedge
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex ma 5. Color or race w
6. (a) Single, widowed, married, divorced s
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased Feb 1946
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) March 16 (b) Raynell Cunningham Harris
(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 CERTIFICATE FROM

20. DATE OF DEATH: Month Feb Day 28
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ at _____ 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 statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

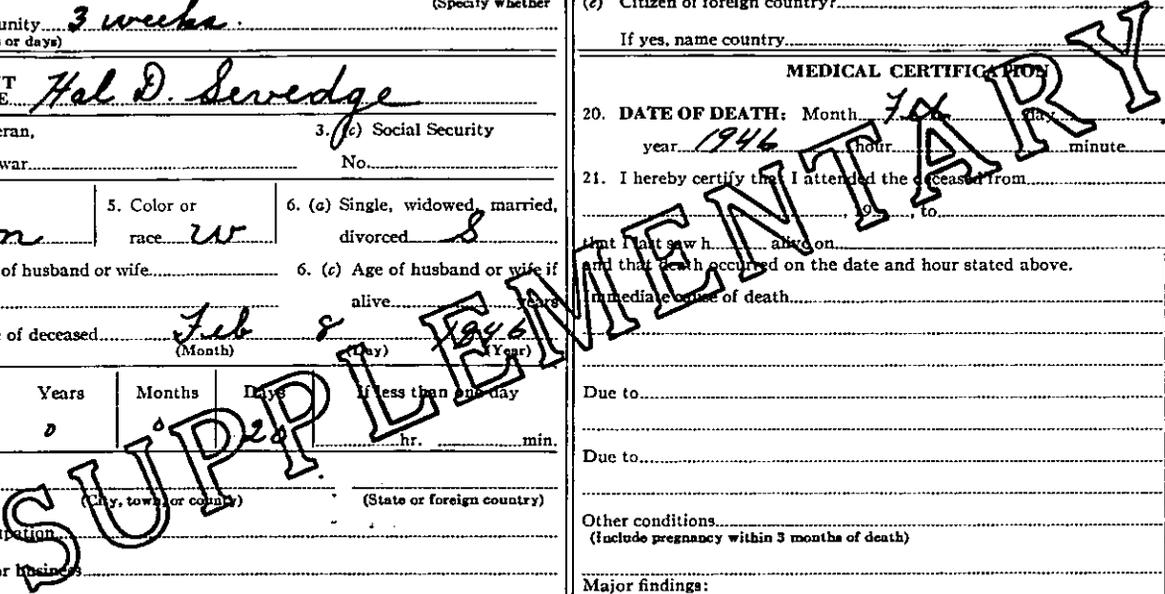
(b) Date of occurrence _____

(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 _____ (M. D. or other) _____

Address _____ Date signed _____



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