

V. S. No. 2
100M-5-43
Rev. 5-17-39
I. X35671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12017

State File No. _____
Registrar's No. 46

FILED APR 12 1946
Registration District No. 368

Primary Registration District No. 6225

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

1. PLACE OF DEATH:
(a) County Bernon
(b) City or town Beck City Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #3 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 32 yrs 7 mo 19 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jasper
(c) City or town Beck City
(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. ✓

3. (a) PRINT FULL NAME FREDERICK SEWARD

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased (unknown) 1894
(Month) (Day) (Year)

8. AGE: Years 52 Months 9 Days ? If less than one day _____ hr. _____ min.

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

10. Usual occupation Student

11. Industry or business _____

MOTHER FATHER

12. Name B. M. Seward

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

14. Maiden name unknown

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

16. (a) Informant Hospital records

(b) Address Nevada Mo.

17. (a) Removal (b) Date thereof 3-31-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield Mo

18. (a) Signature of funeral director Thomas - Russell
(b) Address Springfield Mo.

19. (a) 4-3-46 (b) Mathew Jancy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March Day 30
year 1946 hour 2 minute 30p M.

21. I hereby certify that I attended the deceased from 11-30 1945 to 3-30 1946
that I last saw him alive on March 30 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism
chronic

Due to _____
Due to _____

Other conditions Suppurative arthritis
(Include pregnancy within 6 months of death)
right ankle

Major findings:
Of operations _____
Of autopsy 12/1

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? _____

23. Signature R. G. Hall (Specify type of place) _____
Address Nevada Mo (City, town, or county) _____
Date signed 3-30-46

RECEIVED

District Health Officer No. 7.

District No. 3-46 321

Date Filed 4-5-46

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 Marsh. Cechinger

Licensed Embalmer No. 2656

P. O. Address Nevada 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.