S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11997

State File No. 0

FILED APR 37 1947

Registration District No. 3 / 1

Primary Registration District No. 6076

Registrar's No. 719

1. PLACE OF DEATH:

(a) County Saint Louis

(b) City or town Koch - Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Robert Koch Hospital D
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 32 days (Specify whether
In this community 33 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ~~Saint Louis~~

(c) City or town Saint Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1409a Franklin
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME EDITH SEELYE

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 3

6. (b) Name of husband or wife Louis Berra

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

7. Birth date of deceased 1 (Month) 13 (Day) 1906 (Year)

8. AGE: Years 41 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Carterville (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Waitress

11. Industry or business

FATHER
12. Name Gordon Seelye
13. Birthplace (City, town, or county) MO ? 0 (State or foreign country)

MOTHER
14. Maiden name Lula Pierce ?
15. Birthplace (City, town, or county) Mo ? 0 (State or foreign country)

16. (a) Informant Hospital record
(b) Address Robert Koch Hospital - Koch - MO

17. (a) (Burial, cremation, or removal) (b) Date thereof 3-7-47 (Month) (Day) (Year)
(c) Place: burial or cremation St Louis

18. (a) Signature of funeral director W Kuhlen
(b) Address 3800 Reeves

19. (a) 3-29-47 (Date received local registrar) (b) Ruth Kellen MD (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month March day 6
year 1947 hour 12 minute 46 P.M.

21. I hereby certify that I attended the deceased from 2 - 4, 1947, to 3 - 6, 1947;
that I last saw her alive on 3 - 6, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	1 year +
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

13 B

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Bernard Friedman (M. D. or other) M. D.
Address Koch Hosp, Koch Mo Date signed 3-6-47

(Licensed Embalmer's Statement on Reverse Side)

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.....

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.