S. No. 2
M—1/47
v. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 2 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29506

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7801

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3711 Hartford St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County --
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3711 Hartford St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Chauncey Wilcox Seagrave
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ethel Wyatt Seagrave
6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased 3 (Month) 13 (Day) 1883 (Year)

8. AGE: Years	Months	Days	If less than one day
64	5	3	hr. min.

9. Birthplace Uxbridge, (City, town, or county) Mass. (State or foreign country)
10. Usual occupation Doctor of Dental Surgery
11. Industry or business
FATHER
12. Name Lawson A. Seagrave
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
16. (a) Informant Ethel Seagrave
(b) Address 3711 Hartford St.
17. (a) cremation (Burial, cremation, or removal) (b) Date thereof 8-18-47 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Chapel
18. (a) Signature of funeral director Robert J. Ambruster, Inc.
(b) Address 6633 Clayton Rd.
19. (a) AUG 17 1947 (Date received by local registrar) (b) J. F. Bredel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 16 year 1947 hour 1 minute 30 A.M.
21. I hereby certify that I attended the deceased from 14th., August, 1947, to August 16th., 1947, that I last saw him alive on August 15th., 1947, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Chronic Myocarditis	4 yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause of 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 Victor K. Ultrich (M. D. or other) D.C.
Address 3407 S. Grand Blvd. Date signed 8-16-47

Jefferson City Printing Co.
(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: Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, 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.