No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30629

Registration District No. 1947 Dec 198 1947

Primary Registration District No. 3010

Registrar's No. 198

1. PLACE OF DEATH:
(a) County: CAPE GIRARDEAU
(b) City or town: CAPE GIRARDEAU (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: S.E. MO. HOSPT. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 4 DAYS (Specify whether years, months or days)
In this community: 4 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: CAPE 16
(c) City or town: CAPE GIRARDEAU (If outside city or town limits, write "RURAL") 1
(d) Street No. (If rural, give location) 4 0
(e) Citizen of foreign country? (Name of country) No
If yes, name country

3. (a) PRINT FULL NAME: DALY SEGRAVES
3. (b) If veteran, name war: NO
3. (c) Social Security No.: /

4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife: LILIAN SEGRAVES
6. (c) Age of husband or wife if alive: 45 years
7. Birth date of deceased: 9 (Month) 9 (Day) 1898 (Year)

8. AGE: Years 49 Months 1 Days 11 If less than one day hr. min.

9. Birthplace: ARK (City, town, or county) (State or foreign country)
10. Usual occupation: FARMER
11. Industry or business:
FATHER 12. Name: ROFE SEGRAVES
13. Birthplace: POCAHONTAS ARK (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: ANN ANDERSON
15. Birthplace: POCAHONTAS ARK (City, town, or county) (State or foreign country)
16. (a) Informant: BUTLER SEGRAVES
(b) Address: 715 TANNER ST JACKSON
17. (a) Burial, cremation, or removal: REMOVAL (b) Date thereof: 9/21/47 (Month) (Day) (Year)
(c) Place: burial or cremation: CORNING ARK
18. (a) Signature of funeral director: [illegible]
(b) Address: [illegible]
19. (a) 9-30-1947 (Date received local registrar) (b) C. C. Bummel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 19 year 1947 hour 8 minute 20 A.M.
21. I hereby certify that I attended the deceased from Sept 17th, 1947, to Sept 19, 1947, that I last saw him alive on Sept 19, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: Circulatory Failure
Due to: Hypertensive Cardio-Vascular Disease.
Due to:
Other conditions: (Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

Duration

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: Charles F. Wilson (M. D. or other) M.D.
Address: 727 Broadway Date signed: 9-28-47
Cape Girardeau, Mo.

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 4

District File Number 1047-1266

Date Filed 10-6-47

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 John Allitton

Licensed Embalmer No. 2941

P. O. Address Selkirk

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.