

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____		REG. DIST. NO. 118		PRIMARY REG. DIST. NO. 5440		Registrar's No. 21	
1. PLACE OF DEATH a. COUNTY Gasconade				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Gasconade			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Clay Twnship		c. LENGTH OF STAY (In this place) 4 months		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural (Clay township)		30	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		a. (First) Grace		b. (Middle) Ellen		c. (Last) Selvidge	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 21-1890	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months Days IF UNDER 4 HRS. Min.	
11. BIRTHPLACE (State or foreign country) Missouri				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Geo. Bradford		13b. MOTHER'S MAIDEN NAME Maggie Kurtz		14. NAME OF HUSBAND OR WIFE Harve Selvidge			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Harve Selvidge Bland, R.R.#			
18. CAUSE OF DEATH Enter one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma, generalized ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) Carcinoma of liver DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2-3 wks 6 mo. 1560	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 19 15 to July 3 , 1949, that I last saw the deceased alive on July 2 , 1949, and that death occurred at 5:45 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) D. M. Keller M.D.				23b. ADDRESS Covensville, Mo.		23c. DATE SIGNED July 5, 1949	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7-5-49		24c. NAME OF CEMETERY OR CREMATORY Grove Dale		24d. LOCATION (City, town, or county) (State) Maries County Mo.	
DATE REC'D BY LOCAL REG. July 16, 1949		REGISTRAR'S SIGNATURE Santhony Hackman		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sassmann's Funeral Service-Bland			

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

RECEIVED JUL 9 1919
District Health Officer No. 9,
District File Number

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed

Chester Sussman

Signed _____
Student Embalmer

Licensed Embalmer No. *4178*

P. O. Address *Bland*

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.