

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26805**

FILED SEP 9 1949

BIRTH NO. _____ REG. DIST. NO. 144 PRIMARY REG. DIST. NO. 4234 Registrar's No. 38

1. PLACE OF DEATH a. COUNTY Iron		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Iron	
b. CITY OR TOWN Ironton		c. CITY OR TOWN Ironton	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) Joseph Fredrick Selinger	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH Aug 28 1949
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5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Jan. 25 1869	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 7 Days 3	IF UNDER 2 HRS. Hours 3 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Arcadia Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME John Pope Selinger	13b. MOTHER'S MAIDEN NAME Elizabeth Vogel	14. NAME OF HUSBAND OR WIFE Margarett Selinger
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Ogie Selinger	ADDRESS Ironton Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral apoplexy		5 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio sclerosis, general		10 years
DUE TO (c) Myocarditis, chronic.		33 4X	6 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from April, 1943 to Aug 28, 1949, that I last saw the deceased alive on Aug. 28, 1949, and that death occurred at 2.05 P. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Ben W. Bull, M.D.	23b. ADDRESS Ironton, Mo.	23c. DATE SIGNED 9-1-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 8-30-49	24c. NAME OF CEMETERY OR CREMATORY Liberty	24d. LOCATION (City, town, or county) (State) Arcadia Iron Missouri
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DATE REC'D BY LOCAL REG. Sept. 6, 1949	REGISTRAR'S SIGNATURE Miss Avis Jones	25. FUNERAL DIRECTOR'S SIGNATURE White Funeral Home	ADDRESS Ironton Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 9-8-49

Health Officer No. 4

File Number 949-1188

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.

Student
Student Embalmer

Signed Russel White

Licensed Embalmer No. 3012

P. O. Address Winton Ave

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.