

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35567

FILED NOV 10 1949
BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** State File No. _____ Registrar's No. **9300**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2209 Montgomery		d. STREET ADDRESS (If rural, give location) 2209 Montgomery	

3. NAME OF DECEASED (Type or Print) a. (First) Frank	b. (Middle) M.	c. (Last) Sellers	4. DATE OF DEATH (Month) (Day) (Year) Oct 28-1949
--	-----------------------	--------------------------	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 25, 1886	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HRS. Hours	IF UNDER 15 MIN. Min.
--------------------	-------------------------------	---	---------------------------------------	---	------------------------	-----------------------	-----------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Dillard, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
--	-----------------------------------	--	---

13a. FATHER'S NAME George Sellers	13b. MOTHER'S MAIDEN NAME Laura Mallow	14. NAME OF HUSBAND OR WIFE Lucy Sellers
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil	16. SOCIAL SECURITY NO. 498-09-4574	17. INFORMANT'S SIGNATURE OR NAME Lucy Sellers, 2209 Montgomery	ADDRESS
--	--	--	---------

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, ashenia, 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) Cardio-renal Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) his age to expectant DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 1-31-49
--	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? HH2X
--	--	--

22. I hereby certify that I attended the deceased from **8-20-1949** to **10-28-1949**, that I last saw the deceased alive on **10-27-1949**, and that death occurred at **10:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W.W. Harris M.D.	23b. ADDRESS 3505 Dr. Grand	23c. DATE SIGNED 10-29-49
--	------------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-29-49	24c. NAME OF CEMETERY OR CREMATORY St. Mary	24d. LOCATION (City, town, or county) (State) Dillard, Missouri
--	---------------------------	--	--

DATE REC'D BY LOCAL REG. OCT 29 1949	REGISTRAR'S SIGNATURE J. B. Casar	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington
---	--	---	--------------------------------

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

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 Elmer R. Jodwell

Licensed Embalmer No. 4077

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.