

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36943**

BIRTH NO. 5701-49 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1011

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>Howell</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Mountain View Mo.</b>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <b>Star Route #17.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Burge Hospital</b>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <b>Rita</b>	b. (Middle) <b>Faye</b>	c. (Last) <b>Seats</b>	<b>Nov. 15 1949</b>		
5. SEX <b>f.</b>	6. COLOR OR RACE <b>w.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>infant</b>	8. DATE OF BIRTH <b>Sept 6 - 1949</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Mountain View Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					

13a. FATHER'S NAME <b>Dale Seats</b>	13b. MOTHER'S MAIDEN NAME <b>Zella McGrath</b>	14. NAME OF HUSBAND OR WIFE <b>INFANT</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no.</b>	16. SOCIAL SECURITY NO. <b>No.</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Dale Seats</b>	ADDRESS <b>Mt. View, Mo.</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>life of baby</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congenital Heart disease</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>anemia</b>		<b>17544</b>	

19a. DATE OF OPERATION <b>none</b>	19b. MAJOR FINDINGS OF OPERATION <b>none</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>Springfield, Greene, Mo</b>
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?

22. I hereby certify that I attended the deceased from **11-16**, 19**49**, to **11-17**, 19**49**, that I last saw the deceased alive on **11-17-49**, 19**49**, and that death occurred at **12:03A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Paul J. Busier MD</b>	23b. ADDRESS <b>1635 E. Walnut St.</b>	23c. DATE SIGNED <b>11-17-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>11-19-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Mt. View, Mo.</b>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>11-18-49 W.S. Handley</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. W. Klingner Co. Springfield, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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2  
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**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 \_\_\_\_\_

*Max Rhodes*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 4071

P. O. Address Spring Field

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.