No. 300
10.48

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

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40687

BIRTH NO. 79332-49 REG. DIST. NO. 100 PRIMARY REG. DIST. NO. 3018 Registrar's No. 82

1. PLACE OF DEATH
a. COUNTY: Dent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salem
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Dent
b. COUNTY: Mo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Howesmill Mo.
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Rosemary
b. (Middle):
c. (Last): Sellers

4. DATE OF DEATH (Month) (Day) (Year): Dec. 15, 194

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant
8. DATE OF BIRTH: Dec, 14, 1949
9. AGE (In years last birthday): If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.: 26

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Salem Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Carl Sellers
13b. MOTHER'S MAIDEN NAME: Daphine Pyatt
14. NAME OF HUSBAND OR WIFE: ------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: ---
17. INFORMANT'S SIGNATURE OR NAME: Mrs Carl Sellers
ADDRESS: Howesmill ~~Salem~~ Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematured — INTERVAL BETWEEN ONSET AND DEATH: 26 hr.

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 — 746X

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 ☐ NO ☐

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) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12-14-49, 19___, *to* 12-15-49 19___, *that I last saw the deceased alive on* 12-15-49 19___, *and that death occurred at* 4.00 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE M. M. Hart M.D. (Degree or title)
23b. ADDRESS: Salem Mo.
23c. DATE SIGNED: 12-16-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-16-49
24c. NAME OF CEMETERY OR CREMATORY: Boss Cemetery
24d. LOCATION (City, town, or county) (State): Boss Mo

DATE REC'D BY LOCAL REG.: 12-16
REGISTRAR'S SIGNATURE: M. M. Hart, M.D. 83
25. FUNERAL DIRECTOR'S SIGNATURE: none
ADDRESS:

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED 12/19/49
District Health Officer No. 5,
District File Number 1249795
Date Filed 12/22/49

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 .....

Licensed Embalmer No. .....

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.