

FILED JAN 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

40946

BIRTH NO. _____ REG. DIST. NO. 140 PRIMARY REG. DIST. NO. 3024 Registrar's No. 82

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> COUNTY <u>HOWARD</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>FAYETTE</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>GLASGOW</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>LEE HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) _____	

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>GREENBERY</u> c. (Last) <u>SEIGLE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 25 1949</u>
--	--

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEB. 26 1864</u>	9. AGE (In years last birthday) <u>85</u>
--------------------	-------------------------------	---	--------------------------------------	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>CHARITON COUNTY MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	---	---	--

13a. FATHER'S NAME <u>JACOB SEIGLE</u>	13b. MOTHER'S MAIDEN NAME <u>MARY COX</u>	14. NAME OF HUSBAND OR WIFE <u>MARY McMILLAN</u>
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>John Lea Seigle</u> ADDRESS <u>Glasgow</u>
--	-------------------------------------	---

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>
	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. <u>Chronic myocarditis</u>		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	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 Dec 16, 1949, to Dec 25, 1949, that I last saw the deceased alive on 12-22, 1949, and that death occurred at 11:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Mr. J. Shaw, M.D.</u>	23b. ADDRESS <u>Fayette Mo</u>	23c. DATE SIGNED <u>12-27-49</u>
---	--------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Dec 27, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>	24d. LOCATION (City, town, or county) (State) <u>Glasgow Mo</u>
---	-------------------------------	--	---

DATE REC'D BY LOCAL REG. <u>12-27-49</u>	REGISTRAR'S SIGNATURE <u>Mary K. Shell</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wendley-Grieneroth</u> ADDRESS <u>Glasgow Mo</u>
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

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

45

RECEIVED JAN 4

District Health Officer No. 8,

District File Number

Date Filed 1-10-50

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 *J. Walker Andaley*

Signed
Student Embalmer

Licensed Embalmer No. *3336 J*

P. O. Address *Glasgow Mo*

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.