

BIRTH NO. _____ REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3056 Registrar's No. 161

1. PLACE OF DEATH a. COUNTY RANDOLPH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE IOWA b. COUNTY APPANOOSE	
b. CITY OR TOWN MOBERLY MO		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MOULTON LA 8146	
c. LENGTH OF STAY (in this place) 9 DAYS		d. STREET ADDRESS (If rural, give location) 6	
d. FULL NAME OF HOSPITAL OR INSTITUTION WABASH HOSPITAL			

3. NAME OF DECEASED (Type or Print) EARL D	a. (First)	b. (Middle)	c. (Last) SELLERS	4. DATE OF DEATH (Month) (Day) (Year) 6 30 1950
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APR 23 1878	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months 2 Days 7	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEDICAL DOCTOR	10b. KIND OF BUSINESS OR INDUSTRY PHYSICIAN	11. BIRTHPLACE (State or foreign country) IOWA	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME MOSES SELLERS	13b. MOTHER'S MAIDEN NAME SARAH TIPTON	14. NAME OF HUSBAND OR WIFE MAMIE A SELLERS
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Mr E D Sellers ADDRESS MOULTON IA
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 mos
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) LEUKEMIA, Acute Lymphatic	DUE TO (b) none		
ANTECEDENT CAUSES	DUE TO (c) none		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none		2040

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION BIOPSY OF GLANDS, SPECIAL BLOOD EXAMS	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)
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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?
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22. I hereby certify that I attended the deceased from **June 21**, 19**50**, to **June 30**, 19**50** that I last saw the deceased alive on **June 30**, 19**50**, and that death occurred at **10:22 a.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Henry K Baker MD	23b. ADDRESS Moberly Missouri	23c. DATE SIGNED June 30 50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 7-3-50	24c. NAME OF CEMETERY OR CREMATORY OAKLAND CEM-	24d. LOCATION (City, town, or county) (State) MOULTON IOWA
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DATE REC'D BY LOCAL REG. 7-3-50	REGISTRAR'S SIGNATURE Earl Williams	25. FEDERAL DIRECTOR'S SIGNATURE Mahan and Low ADDRESS Moberly Mo
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RECEIVED JUL 1 1 1950
District Health Officer No. 1
District File Number 7-50-1096
Date Filed JUL 1 4 1950

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 Frank D. DeWitt

Licensed Embalmer No. 3021

P. O. Address Moberly, 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.