

FILED FEB 16 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7210

State File No.

BIRTH NO. 72345-50 REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 33

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Scott</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>Scott</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>SIKESTON</u> | c. LENGTH OF STAY (in this place) <u>LIFE</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>1003 SIKESTON</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Delta Hospital</u> | | d. STREET ADDRESS (If rural, give location) <u>515 NEW ST.</u> | |

| | | | | |
|---|---|---|-------------------------------------|--|
| 3. NAME OF DECEASED (Type or Print) <u>STEPHEN</u> | a. (First) <u>STEPHEN</u> | b. (Middle) <u>F.</u> | c. (Last) <u>SEABAUGH</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>1-10-1951</u> |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>NEVER MARRIED</u> | 8. DATE OF BIRTH <u>NOV-24-1950</u> | 9. AGE (in years last birthday) <u>1</u> MONTHS <u>16</u> DAYS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BABY</u> | 10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/> | 11. BIRTHPLACE (State or foreign country) <u>SIKESTON MO.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |

| | | |
|--|---|--|
| 13a. FATHER'S NAME <u>RUDY CARROL SEABAUGH</u> | 13b. MOTHER'S MAIDEN NAME <u>MARION LAJUNE McCRAW</u> | 14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> | 16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/> | 17. INFORMANT'S SIGNATURE OR NAME <u>Miss Marion Seabaugh</u> ADDRESS <u>Sikeyton Mo</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. | MEDICAL CERTIFICATION | | 12. INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia.</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>Premature infant</u> | | | |
| 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) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 11-24, 1950, to 1-10, 1951, that I last saw the deceased alive on 1-10, 1951, and that death occurred at 12 A.m., from the causes and on the date stated above.

| | | |
|--|-----------------------------------|---|
| 23a. SIGNATURE (Degree or title) <u>Alden B. Carpenter M.D.</u> | 23b. ADDRESS <u>Sikeyton, Mo.</u> | 23c. DATE SIGNED <u>2-1-51</u> |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>1/13/51</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u> |
| 24d. LOCATION (City, town, or county) (State) <u>Sikeyton MO</u> | | |

| | | |
|--|---|--|
| DATE REC'D BY LOCAL REG. <u>Feb 9-51</u> | REGISTRAR'S SIGNATURE <u>Miss Ellen ...</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Welch Funeral Home</u> ADDRESS <u>Sikeyton Mo.</u> |
|--|---|--|

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

No. 300
10-28

003

RECEIVED FEB 12 1951
SCOTT COUNTY HEALTH CENTER
CO. FILE NO. 251-44

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Keaton 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.