

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18389**

FILED **1953**

REG. DIST. NO. **150**

PRIMARY REG. DIST. NO. **5572** Registrar's No. **113**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Prairie		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Independence 7005	
c. LENGTH OF STAY (In this place) 8 days		d. STREET ADDRESS (If rural, give location) 315 E. Walnut	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jackson County Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Jess b. (Middle) _____ c. (Last) Seevers	4. DATE OF DEATH (Month) (Day) (Year) May 19, 1953
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5. SEX male	6. COLOR OR RACE wh.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9-27-1884	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Gen Labor	11. BIRTHPLACE (State or foreign country) Independence, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John W Seevers	13b. MOTHER'S MAIDEN NAME Margaret Neal	14. NAME OF HUSBAND OR WIFE -
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 487-12-9915A	17. INFORMANT'S SIGNATURE OR NAME Wm Seevers - Indep Mo	ADDRESS Indep Mo
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Valvular Heart Disease		
	DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS 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 <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) 4214
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 **5-11-53**, 19**53**, to **5-19-53**, 19**53**, that I last saw the deceased alive on **5-18-53**, 19**53**, and that death occurred at **1:45 AM** from the causes and on the date stated above.

23a. SIGNATURE Guire-Reyna	(Degree or title) MD	23b. ADDRESS 1032 Prop. Bldg.	23c. DATE SIGNED 5/19/53
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 5/20/53	24c. NAME OF CEMETERY OR CREMATORY Robt	24d. LOCATION (City, town, or county) (State) near Buckner Mo
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DATE REC'D BY LOCAL REG. 5/19/53	REGISTRAR'S SIGNATURE NO Langeford 483	25. FUNERAL DIRECTOR'S SIGNATURE NO Langeford	ADDRESS Lees Summit Mo
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

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

N B Langford

Licensed Embalmer No. _____

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P. O. Address _____

Leis Summit

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.