

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10865**
Registrar's No. **5-7**

BIRTH NO. **FILED APR 14 1954** REG. DIST. NO. **324** PRIMARY REG. DIST. NO. **685**

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give name of place) R.F.D. #4, Marshall		c. CITY (If outside corporate limits, write RURAL and give township) R.F.D. #4 Marshall Rural Clay Twp	
c. LENGTH OF STAY (In this place) 20 yrs		d. STREET ADDRESS (If rural, give location) 0970	
d. FULL NAME OF HOSPITAL OR INSTITUTION Rural Clay Twp 10 mi N.E. Marshall Mo			

3. NAME OF DECEASED (Type or Print) Minnie	a. (First)	b. (Middle)	c. (Last) Seba	4. DATE OF DEATH (Month) (Day) (Year) April- 2-1954
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Jan. 19-1890	9. AGE (In years last birthday) Months Days 64 2 13
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and State or Foreign Country) Osage County, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Henry Hemeyer	13b. MOTHER'S MAIDEN NAME Minnie Dettering	14. NAME OF HUSBAND OR WIFE Wm. T. Seba, Marshall, Mo
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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. no	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wm. T. Seba, R.F.D. Marshall, 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 Mon.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Inflammatory Carcinoma (Breast)		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 170 X	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) (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 **Sept. 1, 1953**, to **April 2, 1954**, that I last saw the deceased alive on **April 2, 1954**, and that death occurred at **5:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C. L. Lawless, M.D.	23b. ADDRESS Marshall Mo.	23c. DATE SIGNED 4-2-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/4/1954	24c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery	24d. LOCATION (City, town, or county) (State) R.F.D. Slater, Mo.
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DATE REC'D BY LOCAL REG. 4-5-1954	REGISTRAR'S SIGNATURE Sidney T. Gray	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hill Brothers Slater Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

MAR 28 1961

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 A. C. Hill

Licensed Embalmer No. 3090

P. O. Address State, 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.