

No. 300  
10-48

*Seymour*

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **33675**

FILED OCT 27 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 400

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Independence</b>	c. LENGTH OF STAY (In this place township) <b>8 Weeks</b>	c. CITY OR TOWN <b>Grain Valley</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Independence San &amp; Hospital</b>		STREET ADDRESS (If rural, give location) <b>3 miles North (Sni a Bar TWP</b>	

3. NAME OF DECEASED (Type or Print) <b>Kat Anna B Seymour</b>	a. (First) <b>Anna</b> b. (Middle) <b>B</b> c. (Last) <b>Seymour</b>	4. DATE OF DEATH <b>Oct 17 1955</b>
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5. SEX <b>F M</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan 11 1872</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Spithville Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>John Williams</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Owen</b>	14. NAME OF HUSBAND OR WIFE <b>Lee Seymour</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Lee Seymour</b>	ADDRESS <b>Grain Valley Mo</b>
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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 <b>8 week</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>-</b> DUE TO (c) <b>331X</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Deafness Mellitus</b>			<b>?</b>

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)
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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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Aug 22, 1955, to Oct 17, 1955, that I last saw the deceased alive on 10-17, 1955, and that death occurred at 6:10 A.M., from the causes and on the date stated above.

23a. SIGNATURE <b>J. A. Williams</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>Oak Grove Mo</b>	23c. DATE SIGNED <b>10-18-55</b>
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24. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Oct 19 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Blue Springs</b>	24d. LOCATION (City, town, or county) (State) <b>Blue Springs Mo</b>
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DATE REC'D BY LOCAL REG. <b>10-19-55</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS <b>Walt Funeral Home Blue Springs Mo</b>
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WRITE PLAINLY—USING UNFADING 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.....  
Signature of Student Embalmer

Signed *R. Bluff*.....

Licensed Embalmer No. *235*.....

P. O. Address *Blue Spring*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.