

FILED MAR 22 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11403

State File No. _____

318

1003

2597

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>St. Louis, MO.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>ST. LOUIS, MO.</u>		c. CITY OR TOWN <u>Bonne Terre</u>	
c. LENGTH OF STAY (in this place)		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Pacific Empl Hosp. Am.</u>		e. STREET ADDRESS (If rural, give location) <u>310 Center St. 0971</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>EWEL</u>	b. (Middle) _____	c. (Last) <u>SEAL</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March - 4 - 1956</u>
-------------------------------------	------------------------	-------------------	-----------------------	--

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>2-5-1884</u>	9. AGE (In years last birthday) <u>72</u>	# UNDER 1 YEAR Months <u>1</u> Days _____	# UNDER 2 REE. Hours _____ Min. _____
--------------------	-------------------------------	--	----------------------------------	---	---	---------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRAKEMAN</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>P.R.</u>	11. BIRTHPLACE (City and State of Parent Country) <u>Aradia MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>Union Co</u>
---	---	--	--

13a. FATHER'S NAME <u>William H. Seal</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Weddabee</u>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>702-16-6468</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Rowland Seal</u>	ADDRESS <u>Bonne Terre, Mo</u>
--	--	---	--------------------------------

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Rabdomyosarcoma of chest wall</u>		DUE TO (b) <u>METASTASES TO LUNG + SKIN</u>		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <u>BRONCHIO PNEUMONIA</u>		
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 checked="" 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 type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from Dec-19, 1955, to March-4, 1956, that I last saw the deceased alive on March-4, 1956 and that death occurred at 2:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Edward J. Moran</u>	(Degree or title) <u>MD - Missouri Lic. Physician</u>	23b. ADDRESS <u>St. Francois Ave. Park</u>	23c. DATE SIGNED <u>March 12</u>
---------------------------------------	---	--	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>3-4-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Francois Ave. Park</u>	24d. LOCATION (City, town, or county) (State) <u>Bonne Terre MO</u>
--	-------------------------	--	---

DATE REC'D BY LOCAL REG. <u>MAR 13 1956</u>	REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Sparko Funeral Home</u>	ADDRESS <u>Bonne Terre MO</u>
---	--	---	-------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

Everett Sparks

Licensed Embalmer No. *42*

P. O. Address *Pomona*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.