

Health, Welfare, Public Service

300  
-57

THE DIVISION OF HEALTH AND HUMAN SERVICES  
STANDARD CERTIFICATE OF DEATH

32160

STATE FILE NUMBER

FILED OCT 4 1957

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 4244

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>North Dakota</u> b. COUNTY <u>McHenry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Saukas City Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Drake</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lakeside</u>		Length of stay in lb <u>25 days</u>	d. STREET ADDRESS (If outside, give location). <u>335</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Johan</u> Last <u>Seehafer</u>			4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1957</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11-1907</u>
9. AGE (In years last birthday) <u>50</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>North Dakota</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Ferdinand Seehafer</u>	
13b. MOTHER'S MAIDEN NAME <u>Marie Oberhammer</u>		14. NAME OF HUSBAND OR WIFE <u>Viola Seehafer</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>none</u>	
17. INFORMANT <u>Viola Seehafer - wife</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Acute &amp; Chronic Glomerulonephritis</u> DUE TO (c) <u>Congenital malformation kidneys</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>15 years.</u> <u>50 years.</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Secondary anemia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>  </u> Month, Day, Year a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Aug 17, 1957</u> to <u>Sept. 10, 1957</u> and last saw <sup>her</sup> him alive on <u>Sept 10, 1957</u> Death occurred at <u>5:15 P. m</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Raymond W. Hanna, D.O.</u> (Degree or title)		22b. ADDRESS <u>12007 E. 47th N.C. Mo</u>	
22c. DATE SIGNED <u>9/10/57</u>		22d. LOCATION (City, town, or county) (State) <u>Drake, No. Dakota</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Sept 10-57</u>	23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR <u>Reed J. Howe - Baytown</u> ADDRESS <u>  </u>		25. DATE RECD. BY LOCAL REG. <u>9-11-57</u>	26. REGISTRAR'S SIGNATURE <u>Reva Minshall</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.  
Raymond W. Hanna



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 *Robert L. Kessler* .....

Licensed Embalmer No. ....  
P. O. Address .....

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.