

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43566

STATE FILE NUMBER

FILED DEC 30 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1400

V. S. 300  
Rev. 1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Secretary in linear connection in the specific manner required by 193.140 MoRS 1949.

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <b>Euchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Euchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>St. Joseph</b> <i>0119</i>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Osteopathic Hosp.</b>		Length of stay in 1b <b>65 yrs.</b>	
d. STREET ADDRESS <b>917 South 16th St.,</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Amanda</b> Middle <b>Seitter</b> Last <b>Seitter</b>		4. DATE OF DEATH <b>Dec. 19, 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19, 1875</b>
9. AGE (In years last birthday) <b>82</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and state or country) <b>New Point, Missouri.</b>
12. CITIZEN OF WHAT COUNTRY? <b>US A</b>		13a. FATHER'S NAME <b>Christian Feitz</b>	
13b. MOTHER'S MAIDEN NAME <b>Anna Heuggler</b>		14. NAME OF HUSBAND OR WIFE <b>Jacob F. Seitter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>487-14-6922</b>	
17. INFORMANT <b>Frank Seitter, St. Joseph, Missouri</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral anoxemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Apoplectic Stroke</b>		<b>1 1/2 days</b>	
DUE TO (c) <b>Uremic Poisoning</b>		<b>1 1/2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Possible Intestinal Cancer</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>	
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.) <b>334XH</b>	
20c. TIME OF INJURY Hour <b>12:15</b> Month, Day, Year <b>December 19, 1957</b> a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <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 <b>St. Joseph, Missouri</b>	
20g. COUNTY <b>Mo</b>		20h. STATE <b>Mo</b>	
21. I attended the deceased from <b>December 7, 1957</b> to <b>December 19</b> and last saw <sup>her</sup> alive on <b>December 19, 1957</b> Death occurred at <b>12:15</b> <b>P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>H. H. Larson M.D.</b> (Degree or title)		22b. ADDRESS <b>1201 Jule Street</b>	
22c. DATE SIGNED <b>12-21-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>December 21, 1957</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ashland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri.</b>	
24. FUNERAL DIRECTOR <b>Meierhoffer-Fleeman Inc., St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Dec 26, 1957</b>	
26. REGISTRAR'S SIGNATURE <b>Mrs. Robert Fulton</b>			

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 *Albert H. Harrington*

Licensed Embalmer No. 3258 .....  
P. O. Address .... St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.