

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045311

STATE FILE NUMBER

FILED JAN 6 1959 Station District No. 316 Primary Registration District No. 3059 Registrar's No. 483

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</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, give TOWNSHIP only) OR TOWN <u>BONNE TERRE</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>FLAT RIVER</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>BONNE TERRE HAS 2 Wks</u>			Length of stay in hospital	d. STREET ADDRESS (If outside, give location) <u>212. HOUSEH</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LULA E. SEUENING</u>				4. DATE OF DEATH Month Day Year <u>Dec. 27, 1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUN 16, 1880</u>	9. AGE (In years last birthday) <u>78</u>	FUNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MADISON CO. MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
13a. FATHER'S NAME <u>William Schultz</u>		13b. MOTHER'S MAIDEN NAME <u>LIZA SCHULTZ</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN SEUENING</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 Address <u>Mrs. Ellwood Bergman RR 1, MO</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>HEMORRHAGE FROM THE COLON</u>						INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>A DENOCAINOMA OF THE COLON, SUSPECTED.</u>						2.	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1538</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
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 Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>Dec. 14, 1958</u> to <u>Dec. 26, 1958</u> and last saw her alive on <u>Dec. 26, 1958</u> Death occurred at <u>5:30 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>W Paul Dennis M.D.</u> (Degree or title)				22b. ADDRESS <u>Flat River, Mo.</u>		22c. DATE SIGNED <u>12/29/58</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>BURIAL</u>	23b. DATE <u>Dec. 30, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>Leadington, MO</u>			
24. FUNERAL DIRECTOR <u>Reginald Caldwell</u>			ADDRESS <u>Flat River, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 30, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Cather Rudloff</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *P. Caldwell*

Licensed Embalmer No. *2531*.....

P. O. Address *Flat Rweg*.....

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.