

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022070

FILED JUN 17 1959 Registration District No. 383 Primary Registration District No. 5655 STATE FILE NUMBER Registrar's No. 67

1. PLACE OF DEATH a. COUNTY <b>Lawrence</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Scott</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mt. Vernon</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Chaffee</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. State Sanatorium</b>		Length of stay in lb <b>9 days</b>	d. STREET ADDRESS (If outside, give location) <b>233 Yoakum</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Ella</b> Middle <b>Lou</b> Last <b>Slinkard</b>			4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 3 WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1882</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> 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	11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>John Seabaugh</b>		13b. MOTHER'S MAIDEN NAME <b>Cordia Johnson</b>	14. NAME OF HUSBAND OR WIFE

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>None</b>	17. INFORMANT <b>San. records, Mo. State San., Mt. Vernon, Mo.</b>	Address
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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>Mucoid adenocarcinoma, primary right lung</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pulmonary tuberculosis, active</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ 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 COUNTY STATE

21. I attended the deceased from <b>5 - 28 - 59</b> to <b>6 - 6 - 59</b> and last saw her alive on <b>6 - 6 - 59</b> Death occurred at <b>9:45 p.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <b>C. A. Brusher, M.D.</b>	22b. ADDRESS <b>Mt. Vernon, Mo.</b>	22c. DATE SIGNED <b>6-8-59</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-7-59</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>Chaffee, Mo.</b>
24. FUNERAL DIRECTOR <b>H. D. Fossett</b>	ADDRESS <b>Mt. Vernon, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-12-59</b>	26. REGISTRAR'S SIGNATURE <b>Cecil Hendricks</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18 is added by dr's advt 8-16-59--jf

Health, Welfare, Public Service  
300  
-57  
All diseases in Part I must be causally related.

JUN 7 1959

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 *me*....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *W. H. Powell*.....

Licensed Embalmer No. *2201*.....

P. O. Address *St. Vernon*.....

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.