

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045643

FILED VS JAN 9 1961

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 2

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Franklin</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Franklin</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington</b>		Length of stay in 1b <b>6 wks</b>	c. CITY OR TOWN <b>St. Clair</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Francis Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2 miles West</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Jane</b> Last <b>Seay</b>	4. DATE OF DEATH Month <b>Dec.</b> Day <b>29</b> Year <b>1960</b>
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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>1/27/96</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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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>Home</b>	11. BIRTHPLACE (City and state or country) <b>Harrisburg, Illinois</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Charles Cane</b>	13b. MOTHER'S MAIDEN NAME <b>Clara Johnson</b>	14. NAME OF HUSBAND OR WIFE <b>William Seay</b>
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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 Address <b>St. Francis Hosp. Washington, Mo.</b>
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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>Terminal Carcinoma - 1 year</b> <b>Left Ventricular Failure</b> DUE TO (b) <b>Atherosclerosis</b> DUE TO (c) <b>Carcinoma of Bladder</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>10 years</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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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
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21. I attended the deceased from 12:58 to 29 Dec 1960 and last saw her alive on 29 Dec 1960  
Death occurred at 7:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Wm P. Richardson, M.D.</b>	22b. ADDRESS <b>Union, Missouri</b>	22c. DATE SIGNED <b>1 Jan 61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/31/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Clair, Mo.</b>
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24. FUNERAL DIRECTOR <b>Casey Lenox</b>	ADDRESS <b>St. Clair, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>1/4/61</b>	26. REGISTRAR'S SIGNATURE <b>F. P. Stulman</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed B. M. Lewis, Jr.

Licensed Embalmer No. 5090

P. O. Address St. Clair

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.