

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4990 STATE PLATE NO. 61-019463

AMENDED **F** **LED JUN 8 1961**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in 1b <u>X</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5431 Cabanne Blvd.</u> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>D.</u> Last <u>SEALS</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>24</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</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>11/27/92</u>	9. AGE (last birthday) <u>68</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Clinton, La.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Douglas Seals</u>		13b. MOTHER'S MAIDEN NAME <u>Estella Ross</u>		14. NAME OF HUSBAND OR WIFE <u>Clara Seals</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.		17. INFORMANT Address <u>Clara Seals, 5431 Cabanne</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>
IMMEDIATE CAUSE (a) <u>THROMBOSIS OF BIFURCATION OF ABDOMINAL AORTA</u>		YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>	
	DUE TO (c) <u>450.0</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown	
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
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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 JULY 16, 1956 to MAY 24, 1961 and last saw her/him alive on MAY 24, 1961  
Death occurred at 5:20 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>C. Vermillion, M.D.</u> (Degree or title)	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>5/25/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/29/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Walvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo</u>
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24. FUNERAL DIRECTOR <u>Cunningham &amp; Moore, 2405 Marcus</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>MAY 26 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

STATE OF MICHIGAN  
DEPARTMENT OF HEALTH

DATE OF DEATH \_\_\_\_\_ PLACE OF DEATH \_\_\_\_\_

STATE OF MICHIGAN DEPARTMENT OF HEALTH

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 John K. Cunningham  
Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

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.