

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041256

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5699

FILED DEC 1 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 64 Years		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5129 Wyandotte	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First IDA Middle SEUFERT Last SEUFERT		4. DATE OF DEATH Month November Day 11 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-21-1882	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Salisbury, Missouri	12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME Slyster		13b. MOTHER'S MAIDEN NAME Carrie Heimbrook		14. NAME OF HUSBAND OR WIFE Charles Seufert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Dawson Campbell		Address K. C. Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 11 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerosis					
DUE TO (c) _____					
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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
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 <u>Nov 1, 61</u> to <u>Nov 11, 61</u> and last saw ^{her} _{him} alive on <u>Nov 11, 61</u> Death occurred at <u>4:45 P.M.</u> <u>P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22. SIGNATURE <i>William F. Sanders</i> (Degree or title)			22b. ADDRESS <u>411 West 26th St. KC Mo</u>		22c. DATE SIGNED <u>11/13/61</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-14-61	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah		23d. LOCATION (City, town, or county) Kansas City, Missouri	
24. FUNERAL DIRECTOR Freeman Mortuary		ADDRESS Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 11-14-61	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>	

ITEM NO. SHOULD READ

BY AFFIDAVIT OF **William F. Sanders** MEDICAL CERTIFICATION

The Hon. F. Sanders

411 NICHOLS RD.

VA. 1-8868

ROOM 231

1-5

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 *Ralph O. Howell*

Licensed Embalmer No. *5004*

P. O. Address *K. C. 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.