

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-009623
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 352 Primary Registration District No. _____ Registrar's No. 14

FILED MAR 5 1962	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Janey</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bronson</u> Length of stay in lb <u>2 weeks</u></p> <p>c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Steggs Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Janey</u></p> <p>c. CITY OR TOWN <u>Chadwick</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print)</p> <p style="text-align: center;">First Middle Last <u>Ida Smith Seward</u></p>	<p>4. DATE OF DEATH</p> <p style="text-align: center;">Month Day Year <u>Feb. 9, 1962</u></p>
<p>5. SEX <u>Female</u></p> <p>6. COLOR OR RACE <u>White</u></p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, given if retired) <u>Housewife</u></p>	<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>Mar 6 1888</u> 9. AGE (last birthday) <u>73</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) <u>Lead Hill, Arkansas, U.S.A.</u></p> <p>12. CITIZEN OF WHAT COUNTRY _____</p>
<p>13a. FATHER'S NAME <u>Carrol Smith</u></p> <p>13b. MOTHER'S MAIDEN NAME <u>Betty Manley</u></p>	<p>14. NAME OF HUSBAND OR WIFE <u>George Seward</u></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u></p> <p>16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>George Seward</u> Address <u>Chadwick, Mo.</u></p>
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p style="text-align: center;">PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Cardiac arrest</u></p> <p style="text-align: center;">DUE TO (b) <u>Myocardial Infarction</u></p> <p style="text-align: center;">DUE TO (c) <u>Arteriosclerosis</u></p> <p style="font-size: small;">Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p style="text-align: center;">PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> <p style="text-align: right;">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</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____</p> <p>20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____</p> <p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/></p> <p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p> <p>20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____</p>	<p>21. I attended the deceased from <u>2-1-59</u> to <u>2-9-62</u> and last saw her alive on <u>2-9-62</u></p> <p>Death occurred at _____ <u>8:49 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p> <p>22a. SIGNATURE <u>Roy Gillespie M.D.</u> (Degree or title) 22b. ADDRESS <u>Bronson Mo.</u> 22c. DATE SIGNED <u>3/3/62</u></p>
<p>23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>burial</u></p> <p>23b. DATE <u>2/12/62</u></p> <p>23c. NAME OF CEMETERY OR CREMATORY <u>Epiph</u></p> <p>23d. LOCATION (City, town, or county) (State) <u>Lead Hill, Ark.</u></p>	<p>24. FUNERAL DIRECTOR <u>Holt Memorial Chapel - Bronson, Mo.</u> ADDRESS _____</p> <p>25. DATE RECD. BY LOCAL REG. <u>2-28-62</u></p> <p>26. REGISTRAR'S SIGNATURE <u>Helen Campbell</u></p>

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

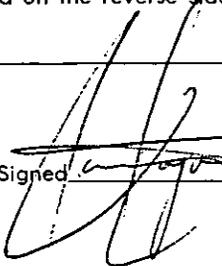
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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  _____
Licensed Embalmer No. _____

P. O. Address Harrison, Ark.

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.