

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-039880

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 268

FILED NOV 14 1962

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <u>MO.</u> b. COUNTY <u>ST. CHARLES</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. CHARLES</u> | | Length of stay in 1b <u>47 YRS</u> | c. CITY OR TOWN <u>ST. CHARLES</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>423 JACKSON</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>423 JACKSON</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED First Middle Last <u>MINNIE KATHERINE SEAY</u> | | | 4. DATE OF DEATH Month Day Year <u>NOV. 7 1962</u> |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 24, 1876</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | 9. AGE (last birthday) <u>86</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. |
| 11a. FATHER'S NAME <u>GEORGE HENRY SCHNEIDER</u> | | 11b. MOTHER'S MAIDEN NAME <u>MINNIE FEY</u> | 11. BIRTHPLACE (City and state or country) <u>HAMBURG MO</u> |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 13. SOCIAL SECURITY NO. <u>NONE</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
| 13a. FATHER'S NAME | | 14. NAME OF HUSBAND OR WIFE <u>BENJAMIN SEAY</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> | | 17. INFORMANT Address <u>MRS. HALIE PUND ST. CHARLES, MO.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>8-9 days</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. Cerebral arteriosclerosis</u> | | | 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 checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> | 20b. SUICIDE <input type="checkbox"/> | 20c. 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>4-6-60</u> , to <u>11-7-62</u> and last saw her ^{him} alive on <u>11-3-62</u> . Death occurred at <u>11 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>J. F. Connerford M.D.</u> | | 22b. ADDRESS <u>114 N. Main St. Charles Mo</u> | 22c. DATE SIGNED <u>11-9-62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>10 NOV. 1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE CEMETERY</u> | 23d. LOCATION (City, town, or county) (State) <u>ST. CHARLES MO.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>PRINSTER-BAUE F.H. INC. ST. CHARLES, MO.</u> | | 25. DATE RECD. BY LOCAL REG. <u>NOV 9, 1962</u> | 26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u> |

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 Frederic W. Bane

Licensed Embalmer No. 4607

P. O. Address St. Charles, 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.