

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-042566**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 340 Primary Registration District No. 6149 Registrar's No. 83

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED OCT 29 1963**

VS 300  
Rev. 4/59

1 1030  
2 1007  
3 2  
4 0  
5 1  
6  
7 0  
8 2  
9 X  
10  
11 103  
12 91-3  
13 20

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>4 Mi - East Fisk Mo</u>		c. CITY OR TOWN <u>Sikeston</u>	
Length of stay in 1b		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>RURAL - U.S. Highway 60</u>		d. STREET ADDRESS (If outside, give location) <u>515 S. NEW MADRID ST.</u>	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUDY CARROLL SEABRUGH</u>			4. DATE OF DEATH Month Day Year <u>10 - 13 - 1963</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>2-19-1931</u>
9. AGE (last birthday) <u>32</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEYER DEPT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. Utilities</u>	11. BIRTHPLACE (City and state or country) <u>Sikeston Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>FRANK SEABRUGH</u>	
13b. MOTHER'S MAIDEN NAME <u>MILDRED WARNES</u>		14. NAME OF HUSBAND OR WIFE <u>ALICE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES II ARMY AIR FORCE</u>		16. SOCIAL SECURITY NO. <u>FRANK SEABRUGH Sikeston Mo.</u>	
17. INFORMANT <u>FRANK SEABRUGH Sikeston Mo.</u>		Address	
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>Fractured skull</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Killed in a head-on collision between his car and one driven by Charles Jr. Webb on Highway 60 1 1/2 miles west of Dudley, Mo.</u>			
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 checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>see above</u>	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>4:00 A.M. 10-13-63</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway 60</u>	
20e. CITY, TOWN, OR LOCATION <u>Dudley, Stoddard County, Mo. R. 1</u>		20f. COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>7:00 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Marsh Watkins</u> (Degree or title) <u>Coroner</u>		22b. ADDRESS <u>Dexter, Missouri</u>	
22c. DATE SIGNED <u>10-15-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-16-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>	23d. LOCATION (City, town, or county) (State) <u>Sikeston Mo.</u>
24. FUNERAL DIRECTOR <u>Wells Funeral Home Sikeston Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-17-63</u>	26. REGISTRAR'S SIGNATURE <u>U. S. ...</u>

USE BLACK INK OR TYPEWRITER RIBBON

OCT 24 1963

OCT 30 1963

OCT 29 1963

DEC 17 1963

FEB 4 1964

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 Raymond News

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.