

DEC 28 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

42338

Do not use this space.

1. PLACE OF DEATH

(a) County St. Francois Registration District No. 774
(b) Township St. Francois Primary Registration District No. 6018B
(c) City Essex (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Seyilda Jane Norwine
(a) Residence, No. _____ St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. C. Norwine

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 30, 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 7 5

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at Home
9. Industry or business in which work was done, as saw mill, bank, etc. Retail Merchant
10. Date deceased last worked at this occupation (month and year) 12-5-37 11. Total time (years) spent in this occupation 35

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington Mo13. NAME Charles Springer14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Delaware15. MAIDEN NAME Eliza Martin16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo17. INFORMANT (ADDRESS) Flat River Mo
Mrs. Abram Bequette

18. BURIAL, CREMATION, OR REMOVAL

PLACE Parkview DATE 12-5-37

19. FUNERAL DIRECTOR (ADDRESS) Goodwin
Flat River Mo20. FILED 12-9 1937 O. B. Barrar Mo
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-5-3722. I HEREBY CERTIFY, That I attended deceased from Dec, 1937, to 12-5, 1937.I last saw her alive on 12-5-37. Death is said to have occurred on the date stated above, at 8:30 a. m.

The principal cause of death and related causes of importance were as follows:

Progressive gallbladder
Chr. myocarditis

Date of onset unt.

Other contributory causes of importance:

hypertension
Chr. interstitial nephritis

Name of operation none Date of _____What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Harold O. Gaebe, M. D.(Address) Desloge Mo

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STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....
..... L. E.
No..... or by....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH
 (a) County St. Francois Registration District No. 774
 (b) Township St. Francois Primary Registration District No. 6018B Registered No. 738
 (c) City..... (d) Street No.....
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Seguilda J. Herman
 (a) Residence, No. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
72 7 5
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
 FATHER
 13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
 MOTHER
 15. MAIDEN NAME
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
 17. INFORMANT (ADDRESS)
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19..
 19. FUNERAL DIRECTOR (ADDRESS)
 20. FILED 19.. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-5-1937
 22. I HEREBY CERTIFY, That I attended deceased from .. to .., 19..
 I last saw h..... alive on .., 19..... Death is said to have occurred on the date stated above, at..... m.
 The principal cause of death and related causes of importance were as follows:
 Date of onset
 Other contributory causes of importance:
Broken hip Feb 15 1931
 Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? fall Date of injury 3-15, 1931
 Where did injury occur? fell on kitchen floor
 other than other than (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place
in home
 Manner of injury fall on floor of her home
 Nature of injury fr. R. hip
 24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify
 (Signed) Harold C. Galbreath, M. D.
 (Address) Deeridge Mrs

SUPPLEMENTARY

N. B. --Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

