

RECORDED MAR 9 1939

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

5451  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1002 Registered No. 650  
 (c) City Kansas City (d) Street No. Lakeside Hospital St.  
 (If death occurred in Hospital of 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

Clarence Seck  
 (a) Residence, No. 3026 Harrison 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Anna Seck  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) October 20, 1899  
 7. AGE YEARS 41 MONTHS 3 DAYS 24 If LESS than 1 day, ..... hrs. or ..... min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Salesman  
 9. Industry or business in which work was done, as saw mill, bank, etc. Wholesale Gro. Co.  
 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) Wes., Kansas  
 FATHER 13. NAME Jacob H. Seck  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany  
 MOTHER 15. MAIDEN NAME Mary Miller  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wes., Kansas  
 17. INFORMANT (ADDRESS) Mrs. Anna Seck 3026 Harrison  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Wes., Kansas DATE Feb. 16, 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/14, 1939  
 22. I HEREBY CERTIFY, That I attended deceased from 2/10, 1939, to 2/14, 1939  
 I last saw him alive on 2/14, 1939. Death is said to have occurred on the date stated above, at 3:30 Am.  
 The principal cause of death and related causes of importance were as follows:  
Lobar Pneumonia Date of onset 2 weeks  
Myocarditis acuta  
Pulmonary Edema few hours  
 Other contributory causes of importance:  
Chronic Arteriosclerosis  
 Name of operation no op. done Date of .....  
 What test confirmed diagnosis? ..... 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? No.  
 If so, specify .....  
 (Signed) Dr. J. H. Hill M. D.  
 (Address) 3024 Harrison

19. FUNERAL DIRECTOR (NAME) (ADDRESS) QUIRK & TOBIN CO. Kansas City, Mo.  
 20. FILED 415 M. M. Brown Local Registrar.

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.

**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 \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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 this body is not embalmed, above space should be left blank.**