

1939 OCT 18 1939

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

31631  
Do not use this space.  
3729

1. PLACE OF DEATH  
 (a) County JACKSON Registration District No. 399  
 (b) Township KAW Primary Registration District No. 1002 Registered No. \_\_\_\_\_  
 (c) City KANSAS CITY (d) Street No. MEMORAH HOSPITAL St. \_\_\_\_\_  
 (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 49 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME MISS NETTIE C. SEYMOUR  
 (a) Residence, No. 1040 WEST 72ND St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) SEPT-10-1871

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>68</u>	<u>0</u>	<u>0</u>	<u>15</u>	

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. SALES LADY  
 9. Industry or business in which work was done, as saw mill, bank, etc. ROCK FLOWER Co.  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation 35

12. BIRTHPLACE (CITY OR TOWN) RAVERMA (STATE OR COUNTRY) OHIO

FATHER 13. NAME MILES C. SEYMOUR  
 14. BIRTHPLACE (CITY OR TOWN) OHIO (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME SHARILLA JUDD  
 16. BIRTHPLACE (CITY OR TOWN) OHIO (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT MEMORAH HOSPITAL (ADDRESS) 4949 ROCKHILL ROAD

18. BURIAL, CREMATION, OR REMOVAL PLACE ELMWOOD DATE SEPT-27-1939

19. FUNERAL DIRECTOR (NAME) D.W. NEWCOMER'S SONS (ADDRESS) 1401- BRUSH CREEK BLVD

20. FILED Sept 27 1939 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) SEPT 25 1939

22. I HEREBY CERTIFY That I attended deceased from August 20 1939 to September 25 1939  
 I last saw her alive on September 24 1939. Death is said to have occurred on the date stated above, at 7:50 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Lobar pneumonia - type 13  
ruptured gall bladder with peritonitis, cholecystitis with stones  
 Date of onset 9-21-39

Other contributory causes of importance: \_\_\_\_\_  
ruptured gall bladder with peritonitis, cholecystitis with stones

Name of operation cholecystectomy Date of 8-21-39  
 What test confirmed diagnosis? specimen 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) [Signature] M. D.  
 (Address) 1002 S. ADAMS ROAD

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.

2-4-30

**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 *George M. Collier*

Licensed Embalmer No. *3839*

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.**