

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH: **3**
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1119 Grand Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community Sixty years 25 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME HENRY C. SEESTED
3. (b) If veteran, name war no
3. (c) Social Security No. none

4. Sex Male
5. Color or race Wh
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Theresa Seested
6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased Jan 1st 1863
(Month) (Day) (Year)

8. AGE: Years 77 Months 0 Days 19
If less than one day hr. _____ min. _____

9. Birthplace Schleswisch Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Architect

11. Industry or business Building Inspector, K.C.M.

12. Name Karl J. Seested

13. Birthplace Schleswisch Germany
(City, town, or county) (State or foreign country)

14. Maiden name Agathe Hennichon

15. Birthplace Schleswisch Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Karl Seested
(b) Address 6378 W 79th St, Overland Park, Kansas

17. (a) Burial (b) Date thereof 2-22-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director J.W. Wagner
(b) Address Kansas City, Mo.

19. (a) Jan. 21, 1940 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 5435 Rockhill Road
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 20th
year 1940 hour 12 minute 55 P.M.

21. I hereby certify that I attended the deceased from Jan 1936, 1936, to Jan 20, 1940
that I last saw him alive on Jan 15, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis
Due to Coronary Sclerosis
Due to CHD

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy none

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature George C. Lee (M. D. _____)
Address 1630 Prof Bldg Date signed 1-21-40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

WRITE PLAIN!—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Cecil R. Matthee

Licensed Embalmer No. 3807

P. O. Address Ke. 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 this body is not embalmed, above space should be left blank.