

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 288

1. PLACE OF DEATH:  
(a) County GREENE  
(b) City or town Springfield  
(c) Name of hospital or institution: St. Johns Hosp.  
(If not in hospital or institution, write street number or location) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days) 330

3. (a) PRINT FULL NAME John Seaton  
8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Martha Caton 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
About 80 unknown \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Geo. Seaton  
13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ralph Seaton  
(b) Address Reed Springs, Mo.

17. (a) Burial (b) Date thereof April 26 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Day, Missouri

18. (a) Signature of funeral director H. H. Lonmeyer  
(b) Address Springfield, Mo.

19. (a) 4/26/40 (b) W. E. Handley M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Stone  
(c) City or town Rural  
Near (If outside city or town limits, write "RURAL")  
(d) Street No. Reed Springs, Missouri  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25  
year 1940 hour 4 minute 30 AM  
21. I hereby certify that I attended the deceased from Oct 4  
1935, to April 24, 1940  
that I last saw him alive on April 24, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure Duration 2 years

Due to Arteriosclerotic Heart Disease 2 years

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) 95 P<sup>2</sup>

PHYSICIAN  
Major findings: Of operations None  
Of autopsy None  
Underline the cause to which death should be charged statistically

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? 984

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature E. E. Glenn (M. D. or other) \_\_\_\_\_  
Address Springfield, Mo. Date signed \_\_\_\_\_

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.

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**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.**

X