

REC'D MAY 15 1940

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

15417
Do not use this space.

1. PLACE OF DEATH

(a) County Livinston Registration District No. 516
(b) Township Wheeling Primary Registration District No. 5682 Registered No. _____
(c) City Wheeling (d) Street No. _____ 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

407 Lester Albert Seely
(a) Residence, No. Wheeling Mo St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Elizabeth Seely
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 17 1849
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
92 10 28
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. Retired
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Norwalk 1
(STATE OR COUNTRY) Connecticut

FATHER 13. NAME Adam Seely 1
14. BIRTHPLACE (CITY OR TOWN) Connecticut 1
(STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME _____
16. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY)

17. INFORMANT Mrs Elizabeth Seely
(ADDRESS) Wheeling Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Wheeling cem DATE April 16 1940

19. FUNERAL DIRECTOR Smiley Funeral Home
(ADDRESS) Wheeling Mo

20. FILED _____ 19 _____
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) APRIL 14 1940

22. I HEREBY CERTIFY, That I attended deceased from Nov 2 1940, to APRIL 14 1940

I last saw h. im. alive on APRIL 14 1940. Death is said to have occurred on the date stated above, at 2 P. m.

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

Chronic Myocarditis Date of onset _____

Other contributory causes of importance:
Cardio-vascular
Renal disease

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? _____ 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) D. F. Youll D.O.
4600 (Address) Wheeling, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERMANENT RECORD

RECEIVED

District Health Officer No. 11,
District File Number 540-723

Date Filed MAY 9 1940

STATEMENT BY LICENSED EMBALMER

I, Frank L. Smiley, Licensed Embalmer No. 470

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

Frank L. Smiley

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed Frank L. Smiley

Licensed Embalmer No. 470

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15-417

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 516

Primary Registration District No. 5682

Registrar's No.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County... Livingston

(b) City or town... Wheeling, W. Va.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
In this community..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(If outside city or town limits write "RURAL")

(d) Street No.....
(If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME Lester Albert Seely

3. (b) If veteran, name war..... 3. (c) Social Security No.....

20. DATE OF DEATH Month apr day 14
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
19..... to..... 19.....
that I last saw him alive on..... 19.....
and that death occurred on the date and hour stated above.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased.....
(Month) (Day) (Year)

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
92 10 28 hr..... min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

15. Birthplace Morrisville, Connecticut
(City, town, or county) (State or foreign country)

16. (a) Informant M = M = D
(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

Major findings:
Of operations.....

Of autopsy.....

Duration

PHYSICIAN

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?
.....
(Specify type of place) (e) Means of injury.....

23. Signature D. F. Youell (M. D. or other).....
Address Wheeling, W. Va. Date signed.....

SUPPLEMENTAL COPY

