

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.

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

36681
 Do not use this space.

Agate
 NOV 25 1940

1. PLACE OF DEATH *Webster* Registration District No. *20* *996*
 (a) County *Webster* Registration District No. *20* *996*
 (b) Township *Agate* Primary Registration District No. *6199* Registered No. *34*
 (c) City *Agate* (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (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 *Mary E. Seigrist*
 (a) Residence, No. *Marshallfield 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 *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Clayton H. Seigrist*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 12-1872*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 3 21
 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.
 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) *Bel* *1*
 13. NAME *John Gill* *5*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland* *9*
 15. MAIDEN NAME *No Record*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *No Record*
 17. INFORMANT (ADDRESS) *Clayton H. Seigrist*
Agate, Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Agate, Mo* DATE *May 4* 19*40*
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *McMahon Funeral Service*
Marshallfield Mo 6199
 20. FILED *Oct 15* 19*40* *E. Hagler* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 3*, 19*40*
 22. I HEREBY CERTIFY, That I attended deceased from *April 10*, 19*40*, to *May 3*, 19*40*.
 I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at *7:30 a.m.*
 The principal cause of death and related causes of importance were as follows:
Chronic - Parenchymatous - Nephritis.
 Date of onset _____
 Other contributory causes of importance: *121*
 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?
 If so, specify _____ (Signed) *W. F. Cahrick* M. D.
 (Address) *Wingard Mo*

RECEIVED

District Health Officer No. 6,

District File Number 1148-282-7

Date Filed NOV 7 1940

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 conform with the above constitutes grounds for revocation of license.)

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