

No. 2
1-4-41
-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MILED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33958

Registrar's No. 3898

Registration District No. 277

Primary Registration District No. 1002

1. PLACE OF DEATH:

(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:
Cresthaven Convalescent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 wks
In this community 8 yrs 4
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte
(c) City or town RR 6
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Reece Sellars

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, Marrried
6. (b) Name of husband or wife Mrs. W.R. Sellars 6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased Mar 3 1860
(Month) (Day) (Year)

8. AGE: Years 81 Months 7 Days 18
If less than one day hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Alfred Sellars
13. Birthplace No Data (State or foreign country)
14. Maiden name Mary Jones
15. Birthplace No Data (State or foreign country)

16. (a) Informant Mrs W. B. Sellars
(b) Address Rosedale St R 6 K Okon
17. (a) Removal (b) Date thereof Oct 20 41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Durham No

18. (a) Signature of funeral director Simmons Funeral Home While at work? _____ (Specify type of place)
(b) Address _____ (c) Means of injury _____
19. (a) 10/18/41 (b) H. C. The Crowe 20. Signature Neighbor (M) _____
(Date received local registrar) (Registrar's signature) Address 2119 S. 1st St Date signed 10/19/41

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17
year 1941 hour 11:00 minute 00 A.M.

21. I hereby certify that I attended the deceased from Aug 2 1941 to Oct 17 1941
that I last saw him alive on Oct 17 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Bronch pneumonia
Due to Encephalitis
Due to Generalized arteriosclerosis

Other conditions (Include pregnancy within 3 months of death) 83c

Major findings: Of operations _____
Of autopsy _____
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? _____

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

APR 23 1943

FEB 21 1944

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, fact should be so stated above.