

FILED OCT 12 1943
Registration District No. **318**

Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St Louis Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St John Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 Days in Hospital**
(Specify whether in this community _____ years, months or days)

3. (a) PRINT FULL NAME **DONALD LEE SEYMOUR**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **Aug. 22 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 8 hr. min.

9. Birthplace **St Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nil.**

11. Industry or business _____

MOTHER { 12. Name **William Seymour**
FATHER { 13. Birthplace **Chester Ills.**
(City, town, or county) (State or foreign country)
14. Maiden name **Barbara Cheek**
15. Birthplace **Paducah Ky.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Barbara Seymour**

(b) Address **3768 Newsho**

17. (a) **Burial** (b) Date thereof **9-30-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St Matthews Cem**

18. (a) Signature of funeral director **Thos. L. ...**

(b) Address **2906 Gravois Ave.**

19. (a) **SEP 30 1943** (b) **J.F. Bredenk**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3768 Newsho St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **30**
year **1943** hour **3:10** minute **A.M.**

21. I hereby certify that I attended the deceased from **8/22/43**
to **9/30/43**
that I last saw him alive on **9/30/43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia** Duration **7 days**

Due to **Acute Enteritis** Duration **4 days**

Due to **119**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Spontaneous hypertrophy of pylorus**
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? _____

While at work? _____ (Specify type of place) (Means of injury)

23. Signature **W. G. ...** (M. D. or brother)
Address **3615 S. Grand** Date signed **9/30/43**

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.

not embalmed

Signed.....
H. A. Van Tossan

Licensed Embalmer No. *4242*

P. O. Address *2906 Travisan*

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.