

No. 2  
-242  
17-39  
X32873

ED SEP 16 1943

Registration District No. 775

Primary Registration District No. 5650

State File No. ....

Registrar's No. 118

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Sarcoxie Rural - Spring Hill  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 69 years  
(Specify whether years, months or days)

In this community 69 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence **55**

(c) City or town Sarcoxie Rural  
(If outside city or town limits, write "RURAL") **3**

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

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country. .... **1**

3. (a) PRINT FULL NAME Lousia Elizabeth Seneker

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Alonza (Lon) 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased April 16 1869  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 31  
year 1943 hour 8 minute 15 P.M.

21. I hereby certify that I attended the deceased from 8-15-1940 to 8-31-1943.  
that I last saw her alive on 8-31-1943  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>4</u>	<u>15</u>	hr. .... min.

Immediate cause of death Chr, myo carditis 2 yrs. **Duration 2 yrs.**

Due to Chr, nephritis **3 years.**

Due to .....

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

10. Usual occupation Housewife

11. Industry or business .....

12. Name Joseph Baker

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

14. Maiden name Mary Elizabeth Derrick

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

16. (a) Informant Lon Seneker

(b) Address Sarcoxie, Missouri

17. (a) Burial (b) Date thereof Sept. 2, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director Roland C. Engelage

(b) Address Sarcoxie, Missouri

19. (a) ..... (b) .....  
(Date received local registrar) (Registrar's signature)

Other conditions 1318  
(Include pregnancy within 3 months of death)

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? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

While at work? .....

23. Signature W B Galt (M. D. or other)  
Address Sarcoxie, Mo Date signed 9-2-43

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

MOTHER, FATHER

RECEIVED

District Health Officer No. 6,

District File Number 943-1089

Date Filed 9-14-43

**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.

Signed: Geo. B. Orr.  
Licensed Embalmer No. 946  
P. O. Address: 29th Vermont

**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.**

Registration District No. 175 Primary Registration District No. 5650

**1. PLACE OF DEATH:**  
 (a) County Lawrence  
 (b) City or town Rural Spring River Twp  
(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. (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Louisa E. Seneker  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex ♀ 5. Color or race wt 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 April 16 1893  
(Month) (Day) (Year)

**8. AGE:** Years 74 Months 4 Days \_\_\_\_\_ less than one day 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 \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
 (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 \_\_\_\_\_  
 19. (a) Sept. 2 1943 (b) Eunice Greenberg  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_  
 year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_  
 23. Signature \_\_\_\_\_ (M. D. or other)  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

3209