

FILED DEC 22 1944

Registration District No. **376**

Primary Registration District No. **6025**

Registrar's No. **822**

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. State Hospital No. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 23 yrs. 9 mos. 29 das.
(Specify whether

In this community
years, months or days)

3. (a) PRINT FULL NAME PEARL A. SEUFERT

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race W. 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 About 1893
(Month) (Day) (Year)

8. AGE: Years About 51 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Morley, Scott Col., Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation House Work

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 11-14-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cem., Farmington, Mo.

18. (a) Signature of funeral director C. H. Cozean Funeral Home

(b) Address Farmington, Missouri

19. (a) 11-18-44 (b) James J. Nichols
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott **74**
(c) City or town Near Sikeston, **0**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) **0**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 12,
year 1944 hour 1 minute 40 A. M.

21. I hereby certify that I attended the deceased from March 6, 1942, to November 12, 1944,
that I last saw her alive on November 11, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia **Two days**

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

Due to _____
Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy Broncho pneumonia and nephritis.

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? Mo.

(Specify type of place) _____
While at work? _____ Means of injury 0

23. Signature Frank J. Nichols (M. D. _____)
Address Farmington, Mo. Date signed 11-12-44

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

1373

RECEIVED

Health Officer No. 4
District File Number 1244-47
Date Filed 12-20-

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 *C. Hooper*
Licensed Embalmer No. 4084
P. O. Address *Farmington Mo.*

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. 316 Primary Registration District No. 6075

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Rural St. Francois
(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 _____)

3. (a) PRINT FULL NAME Paul A. Seufert
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 ✓
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Alt (Month) (Day) (Year)

8. AGE: Years alt 51 Months _____ Days _____ (Unless than one day) _____ min.
9. Birthplace _____ (City, town, or county) (State or foreign country) Mo.

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 _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan Day 12 Year 1945 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 Bronchitis pneumonia
Duration _____
Due to _____ 12/31
Due to _____

Other conditions Chronic Interstitial Nephritis
(Include pregnancy within 3 months of death)
Major findings: Chronic Interstitial Nephritis
Of operations _____
Of autopsy Bronchitis pneumonia & nephritis
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 name of place)
(e) Means of injury _____
23. Signature Francis J. Nichols (M. D. _____)
Address Farmington, Mo. Date signed 1-1-45

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

SUPPLEMENTARY

Do Not Know. PHYSICIAN
Underline the cause to which death should be charged statistically.

S-42054 - 1944