

No. 2
2-43
5-17-39
35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 23 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35973**

Registration District No. **1**

Primary Registration District No. **3000**

Registrar's No. **415**

1. PLACE OF DEATH:

(a) County **Adair**

(b) City or town **Kirksville**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2 515 South Fourth
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Adair**

(c) City or town **Kirksville**
(If outside city or town limits, write "RURAL")

(d) Street No. **515 S. Fourth**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Bessie Mulford Seprit**

3. (b) If veteran, name war **-**

3. (c) Social Security No. **✓**

4. Sex **female**

5. Color or race **white**

6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Harvey Seprit**

6. (c) Age of husband or wife if alive **41** years

7. Birth date of deceased: **Oct 17 1906**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
40	0	2	hr. min.

9. Birthplace **Adair Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Imsey Mulford**

13. Birthplace **Brushy Co. Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Adie Mulford Howe**

15. Birthplace **Adair Co. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Harvey Seprit**

(b) Address **Kirksville Mo.**

17. (a) **Burial** (b) Date thereof **10-22-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Dak Grove**

18. (a) Signature of funeral director **Davis Funeral Home**

(b) Address **Kirksville Mo.**

19. (a) **11-15-46** (b) **Hate Lambert**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **19**
year **46** hour **3:30** minute **a** M.

21. I hereby certify that I attended the deceased from **1936**
to **Oct. 19 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Hodgkins Disease**
Sarcoma of lymph nodes
of specimen
mixed cell sarcoma

Duration: **10 yrs**
4 yrs

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations: _____
Of autopsy: _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)

(e) Means of injury _____

23. Signature **P. O. Stickler** (M. D. or other) **MD**
Address **Kirksville Mo.** Date signed **10-26-46**

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

6 2-46

NOV 29 1946

10-46-2064
11-16-1946

NOV 26 1946

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 Easley

Licensed Embalmer No. 3755

P. O. Address Hurdle end

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.

2B.
45.
43880

State File No. 1000
Registrar's No. 415

Registration District No. 1 Primary Registration District No. 3000

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirkmoull
(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 _____)

In this community _____ 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 Bessie M. Seft

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 m

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

7. Birth date of deceased Oct 17 1946
(Month) (Day) (Year)

8. AGE: Years 40 Months _____ Days _____ If less than one day hr. _____ 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) _____ (b) _____
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Oct Day 17 Year 1946 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Sympho sarcoma
Schlagpneu disease
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: left cervical lymph glands
Of operations _____
Of autopsy _____

Duration _____
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 R. O. Stubler (M. D. or other) _____
Address Kirkmoull mo Date signed _____

SUPPLEMENTARY

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

34795

35973