

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 7 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

408831

State File No. _____
Registrar's No. **5440**

Registration District No. **149** Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jacks on**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Luke's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **since 12-22-46**
(Specify whether years, months or days) **since childhood**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **800 West 53rd**
(If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country **X**

3. (a) PRINT FULL NAME **Robert William Seaman**

3. (b) If veteran, name war **no.** No. **7591**

4. Sex **male** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Mrs. Nelle Seaman**
6. (c) Age of husband or wife if alive **42** years
7. Birth date of deceased **October 20 1902**
(Month) (Day) (Year)

8. AGE: Years **44** Months **2** Days **5**
If less than one day hr. min.

9. Birthplace **Winfield, Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Real Estate Operator**

11. Industry or business **X**

12. Name **James Robert Seaman**

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

14. Maiden name **Bette**

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

16. (a) Informant **Mrs. Nelle Seaman**

(b) Address **800 W. 53rd St., Kansas City, Mo.**

17. (a) **Cremation** (b) Date thereof **12-28-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Elmwood Cemetery**

18. (a) Signature of funeral director **Stine & McClure**

(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **12-27-46** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **25**
year **1946** hour **6:45** minute **A.** M.

21. I hereby certify that I attended the deceased from **Dec 22**, 19 **46** to **Dec 25**, 19 **46**
that I last saw him alive on **Dec 24**, 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death:
fractured limb
" sacrum
" ribs (at 4-5)
" ruptured bladder
Due to **"**
Due to **"**
Other conditions: **186 lb**
(Include pregnancy within 3 months of death)

*Duration
*Physician
Underline the cause to which death should be charged statistically.

Major findings:
Of operations **Above (Dr. I. S. Brown)**
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **Accident**
(b) Date of occurrence **Dec 22 1946**
(c) Where did injury occur? **H. C. Jackson, Mo.**
(City, town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
home

While at work? **no** (Specify type of place)
(e) Means of injury **fall from 3rd floor**

23. Signature **[Signature]** (If D. one only)
Address **320 W 47th** Date signed **Dec 26 '46**

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

MOTHER FATHER

Dr. Wm. Krehn

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..... *Robert H Reed*

Licensed Embalmer No..... *3745*

P. O. Address..... *148 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.

No. 2
-12-45
5-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 5440

FILED JAN 17 1947

Registration District No. 149

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: St. Luke's Hosp.
(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 Robert William Seaman

3. (b) If veteran, name war _____
3. (c) Social Security No. 495-07-7591

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 25
year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____
_____ 19____ to _____ 19____;
that I last saw h_____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

4. Sex _____ 5. Color or race _____
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: (Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-27-46 (b) Theraldine Hobbs
(Date received local registrar) (Registrar's signature)

Immediate cause of death _____
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 _____

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

SUPPLEMENTARY

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

40831

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.