

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

No. 3007
10.48

BIRTH NO. 12-6-51 REG. DIST. NO. 93 PRIMARY REG. DIST. NO. 5345 Registrar's No. 76

1. PLACE OF DEATH a. COUNTY Dade		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Mo b. COUNTY Dade	
b. CITY (If outside corporate limits, write RURAL and give township) Sac twp		c. CITY (If outside corporate limits, write RURAL and give township) Sac twp 2296	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) Greenfield Mo rt	

3. NAME OF DECEASED (Type or Print)	a. (First) Samuel	b. (Middle) Jackson	c. (Last) Seybert	4. DATE OF DEATH (Month) (Day) (Year) 12-5-51
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH July 5 1855	9. AGE (In years last birthday) 96	IF UNDER 1 YEAR Months 8	IF UNDER 1 YEAR Days 0	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY farmer	11. BIRTHPLACE (State or foreign country) Dade Co Mo. D	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Silas Seybert	13b. MOTHER'S MAIDEN NAME Mary Seybert	14. NAME OF HUSBAND OR WIFE Rebecca Jane Seybert
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	(If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Charley Seybert	ADDRESS Greenfield Mo rt.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		794X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. ANTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) Lockwood (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from After death to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:00a., from the causes and on the date stated above.

23a. SIGNATURE J. W. When Coroner	(Degree or title)	23b. ADDRESS Lockwood Mo	23c. DATE SIGNED 12-5-51
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24a. BURIAL, CREMATION, REMOVAL Burial	24b. DATE 12-7-51	24c. NAME OF CEMETERY OR CREMATORY Greenfield Cem.	24d. LOCATION (City, town, or county) (State) Greenfield Mo
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DATE REC'D BY LOCAL REG. 12-6-51	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE W.R.A.	ADDRESS Greenfield Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DIVISION OF HEALTH OF MD.
District No. 5 - Springfield

RECEIVED (DEC 10 1951

Dist. File 12-51-3279

Date Filed 12-11-51

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 _____

working under my personal supervision.

Student Embalmer No.

Signed W. R. Allison

Signed.....
Student Embalmer

Licensed Embalmer No. 4404

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.