

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-112311-1
STATE FILE NUMBER

FILED MAY 11 1959

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 202

5. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CRAWFORD</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia, Missouri</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Steelville</u> 0280 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR UNIVERSITY OR INSTITUTION <u>Medical Center</u> Length of stay in lb <u>45 DAYS</u>		d. STREET ADDRESS (If outside, give location)		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Melvin Theodore Sellers</u>			4. DATE OF DEATH Month Day Year <u>May 1 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 3 1885</u> 74	9. AGE (In years to birthday) UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Davisville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>George Sellers</u>		13b. MOTHER'S MAIDEN NAME <u>Laura Mallow</u>		14. NAME OF HUSBAND OR WIFE <u>Amanda Sellers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>499-03-1725</u>	17. INFORMANT <u>Hospital Records</u> Address <u>Columbia, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonitis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Adrenal Insufficiency</u>					? <u>2 weeks</u>
DUE TO (c) <u>Staphylococcus Aureus Septicemia 154X</u>					? <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>11 days post-op Resection of Adenocarcinoma of Rectum</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>3-17-59</u> to <u>5-1-59</u> and last saw ^{her} _{him} alive on <u>5-1-59</u> Death occurred at <u>11:17</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Earl J. Wiggles, Jr., M.D.</u>			22b. ADDRESS <u>U. of Mo. Medical Center</u>		22c. DATE SIGNED <u>5/1/59</u>
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <u>May 3 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sellers Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Crawford Co., Mo</u>
24. FUNERAL DIRECTOR <u>Parsons Funeral Service, Columbia Mo</u>		25. DATE RECD. BY LOCAL REG. <u>May 2, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>	

(Licensed Embalmer's Statement on Reverse Side)

Color, colorer, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JUN 9 6 1958

MAY 12 1958

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Douglas P. Gorman*
Licensed Embalmer No. *5037*

P. O. Address *Columbia, N.C.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.