

FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE

MORTUARY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037116

FILED VS. OCT 19 1959

STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 2052 Registrar's No. 332

UNDECEASED

1. PLACE OF DEATH a. COUNTY <u>Pettis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u> Length of stay in 1b <u>8 yrs</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1701 East 16th st.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Pettis</u> c. CITY OR TOWN <u>Sedalia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1701 East 16th st.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>Joseph</u> Last <u>SEIFNER</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>14</u> Year <u>1959</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIAGE STATUS Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-7-1986</u>		9. AGE (last birthday) <u>73</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Pettis Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>					
13a. FATHER'S NAME <u>Henry Herman Seifner</u>				13b. MOTHER'S MAIDEN NAME <u>Alvina Wagoner</u>				14. NAME OF HUSBAND OR WIFE <u>Mary Seifner</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>493-14-7586</u>		17. INFORMANT <u>Mrs. Mary Seifner</u>		Address <u>1701 E. 16th</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>Cerebro-vascular accident</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension, senility</u>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <u> </u> a.m. <u> </u> p.m.		Month, Day, Year <u> </u>											
20d. INJURY OCCURRED WHILE AT WORK <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>Sept. 13, 1959</u> to <u>Oct. 13, 1959</u> and last saw ^{her} him alive on <u>Oct. 13, 1959</u> Death occurred at <u>3 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Albert J. Campbell M.D.</u> (Degree or title)						22b. ADDRESS <u>312 1/2 So. Ohio Sedalia Mo</u>			22c. DATE SIGNED <u>10-15-59</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-16-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		23d. LOCATION (City, town, or county) <u>Sedalia</u>		(State) <u>Mo</u>					
24. FUNERAL DIRECTOR <u>M^c Laughlin Bros. Sedalia</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>10-16-1959</u>		26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>							

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Harold Tempel, Student Embalmer No. 800

working under my personal supervision.

Student Harold Tempel
Signature of Student Embalmer

Signed K.P. McLeary

Licensed Embalmer No. 3153

P. O. Address Sedalia, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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