

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

15250

1. PLACE OF DEATH

County Jackson
Towash Kaw
City Kansas City

Registration District No. 399
Primary Registration District No. 1002
(No. 3440 Garfield)

File No. 2113
Registered No. 2113
St. Ward

2. FULL NAME

Jacob Sieben
(a) Residence No. 3440 Garfield 13 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Veronica Sieben

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

June 4, 1865

7. AGE

62

YEARS

MONTHS

11

DAYS

17

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Steamfitter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Canada

10. NAME OF FATHER

Paul Sieben

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14. INFORMANT (Address)

Paul Sieben
3011 East 87th

15. FILED

723 19 27 M. M. Browne
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

May 21st 1927

17. I HEREBY CERTIFY, That I attended deceased from July 14th 1926, to May 21st 1927 and I last saw him alive on May 21st 1927, and that death occurred, on the date stated above, at 3:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Endocarditis, Acute

CONTRIBUTORY (SECONDARY)

Pus appendix

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF April 16th 1927

2 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. S. Mackey, M. D.

721, 1927 (Address) 726 Lathrop Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Calvary

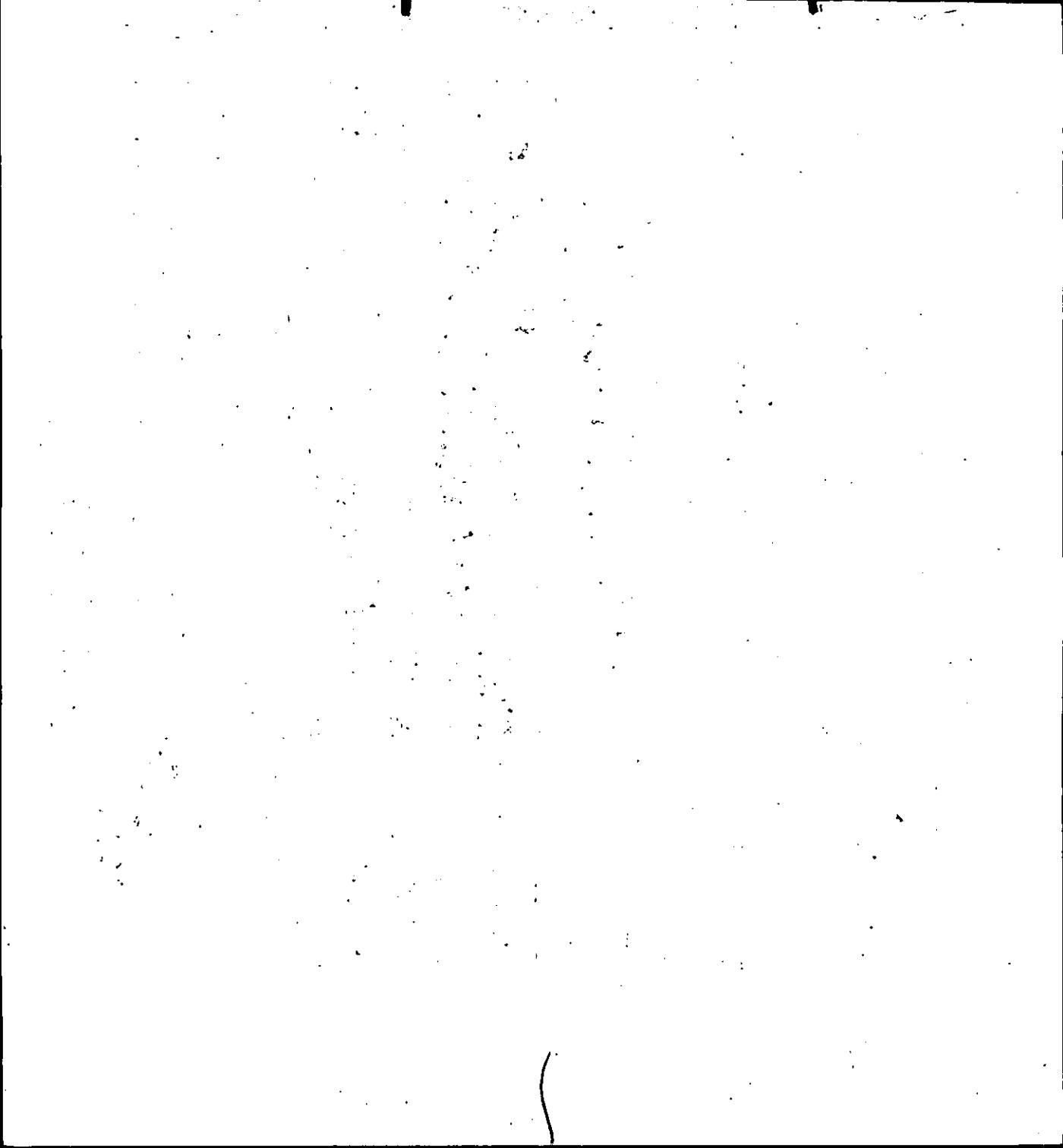
DATE OF BURIAL

5/23 1927

20. UNDERTAKER

The Taylor Funeral Home Inc

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County

Registration District No. 399

File No.

Township

Primary Registration District No. 1002

Registered No. 2119

City

Mana City (No.)

St.

Ward)

2. FULL NAME

(a) Residence No.

St.

Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

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M

W

M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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7. AGE

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(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

FILED

5/23, 19

27 M. M. Brown
asst
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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I HEREBY CERTIFY, That I attended deceased from

19... 19... that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

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DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed).....

, 19 (Address)

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

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20. UNDERTAKER

ADDRESS

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SUPPLEMENTARY

S-15250