

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

Do not use this space.

14139

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis*

Registration District No. *791*  
Primary Registration District No. *1003*  
(No. *St. Lukes Hospital*)

File No.....  
Registered No. *3471*  
St..... Ward)

**2. FULL NAME**

*Kate Dennis Seibert*  
(a) Residence. No. *5825 Bartmer* St., *5* Ward.

(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred *17* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female* 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 *Wm W. Seibert*

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
*abv. 48*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Cape Girardeau*  
(STATE OR COUNTRY) *Mo*

10. NAME OF FATHER *James B. Dennis*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Unknown*  
(STATE OR COUNTRY) *Ala*

12. MAIDEN NAME OF MOTHER *Rachel Cross*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *New Orleans*  
(STATE OR COUNTRY)

14. INFORMANT *W. W. Seibert*  
(Address) *5825 Bartmer*

15. FILED *7 1930* REGISTRAR *May C. Stanley*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 6<sup>th</sup> 1930*

17. I HEREBY CERTIFY, That I attended deceased from *two years* to *4/6/30*, 19..... that I last saw him alive on *4/6/30*, 19..... and that death occurred, on the date stated above, at *10:45 a. m.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Carcinoma originally of breast*  
*50*

*Melanotic Carcinoma* (duration) ..... yrs. .... mos. .... ds.  
CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

3 DID AN OPERATION PRECEDE DEATH? *Squamous* DATE OF.....

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Sam J. Baxendale*, M. D.

*4/6*, 1930 (Address) *5427 Delmar*

\*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

DATE OF BURIAL

*Cape Girardeau Mo* *Apr. 8 1930*

20. UNDERTAKER

ADDRESS

*Alexander Sues* *6175 Delmar*

N. B.—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.

