

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

Do not use this space.

38075

701
1003

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City St. Louis, Mo. (No. 2309 Dodier St.) St. _____ Ward _____

File No.....
Registered No. 11229
St. _____ Ward _____

2. FULL NAME Frederick J. Seibert

(a) Residence. No. 2309 Dodier St. St. 20 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 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male White Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 21 - 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 4 5

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Germany
(STATE OR COUNTRY)

10. NAME OF FATHER John Seibert

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Emma Knyzer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

14. INFORMANT Lena Seibert
(Address) 2309 Dodier St.

15. FILED 29 1930 May 29 1930 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 26th 1930

17. I HEREBY CERTIFY, That I attended deceased from May 27th, 1930, to Nov 26, 1930, that I last saw him alive on Nov 26, 1930, and that death occurred, on the date stated above, at 6 - P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

99 Suplexy cerebral
hemorrhage
(duration) yrs. mos. 1 ds.

CONTRIBUTORY Arterio sclerosis
(SECONDARY)
(duration) yrs. 6 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOEY? no

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) L O Rohlfing, M. D.
Nov 27 1930 (Address) 3126 N. Grand

*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 Zions DATE OF BURIAL Nov. 29 1930

20. UNDERTAKER Hy Leidner ADDRESS 1417
Third St. Market

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.

