

JUN 17 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2177

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Northeast Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 42 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4435 State Line  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME John A. Seigler 246

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 496-01-1438

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Sara G. Seigler  
6. (c) Age of husband or wife if alive 38 years  
7. Birth date of deceased January 19 1898  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Apr 15, 1940 to May 25, 1940; that I last saw him alive on May 24, 1940 and that death occurred on the date and hour stated above.  
Immediate cause of death Myocarditis Duration \_\_\_\_\_

Due to Sub Articular Rheumatism  
Due to Streptococcal Blood Infection  
Other conditions \_\_\_\_\_ (Includes pregnancy within 3 months of death)

Major findings: Of operations no  
Of autopsy no  
PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 3  
23. Signature Dr. J. M. Adkins (M. D. or other) D.D.  
Address 423 Lee Bldg Date signed May 27 1940

8. AGE: Years 42 Months 4 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Kansas City Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Insulator

11. Industry or business Palmolive-Peet Soap Co.

12. Name John J. Seigler

13. Birthplace No record  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Piechowski

15. Birthplace No record  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Sara Seigler

(b) Address 4435 State Line

17. (a) burial (b) Date thereof 5- 28-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Calvary-K.C.K.

18. (a) Signature of funeral director Gates Funeral Home

(b) Address Kansas City, Kansas

19. (a) May 27, 1940 (Date received local registrar) M. M. Crowe (Registrar's signature)

MOTHER FATHER

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.

Albert M. Adkins  
423 Lee Bldg.  
1003 Main

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**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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*Ross Blanford*

Licensed Embalmer No. *4015*

P. O. Address *1815 W 511 st*

**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 this body is not embalmed, above space should be left blank.**