

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.

SEP 16 1940
Registration District No. 26

Primary Registration District No. 5774 B

Registrar's No. 12

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Rural - Hubble Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME William C SIEMERS 562
8. (b) If veteran, name war _____
8. (c) Social Security No. None

4. Sex MALE
5. Color or race W
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JUNE 23 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 1 19 _____ hr. _____ min.

9. Birthplace CAPE GIRARDEAU MO 0
(City, town, or county) (State or foreign country)

10. Usual occupation FARMING

11. Industry or business _____

MOTHER FATHER { 12. Name HENRY Conrad SIEMERS
13. Birthplace GERMANY 6
(City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name HERMINIA BERLING
15. Birthplace CAPE GIRARDEAU CO. 0
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Maria Siemers
(b) Address Gardenville Mo

17. (a) BURIAL (b) Date thereof August 14 - 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Zion Lutheran Cemetery

18. (a) Signature of funeral director Macke-Wilson-Statler
(b) Address Jackson Mo

19. (a) Aug 13 (b) Mrs M. W. Ford
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County CAPE Girardeau
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH Month Aug day 12
year 1940 hour 8 minute 40 A M.
21. I hereby certify that I attended the deceased from Dec 18 - 38
_____, 19____, to Aug 12, 1940
that I last saw h _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Paralysis & general decline
Due to Central Nervous System Dec 18 1939

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death) None

Major findings: _____ PHYSICIAN _____
Of operations _____
Of autopsy _____
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? 22

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature C. R. Schorn by G. S. Schorn (M. D. or other)
Address Jackson Mo Date signed 8-12-40

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.....

Glenn Wilson....., Registered Apprentice No.....
working under my personal supervision.

Signed Glenn Wilson.....

Licensed Embalmer No. 2828.....

P. O. Address Jackson Ms.....

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.