V. S. No. 2
M—11-10-39
Rev. 5-17-39
I X21492

81

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 25 1947

Registration District No. 678

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43513

Primary Registration District No. 3904

Registrar's No.

1. PLACE OF DEATH:
(a) County: Phelps,
(b) City or town: St James (Rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: X
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: X (Specify whether years, months or days)
In this community: 60 2

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri. (b) County: Phelps,
(c) City or town: St James, Missouri.
(If outside city or town limits, write "RURAL")
(d) Street No.: None
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 61 years.

3. (a) PRINT FULL NAME: Conrad Sieber

3. (b) If veteran, name war: X

3. (c) Social Security No.:

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Augusta Sieber

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: November, 22nd, 1862 (Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 8 If less than one day hr. min.

9. Birthplace: Baden, Germany (City, town, or county) (State or foreign country)

10. Usual occupation: Farmer. 6

11. Industry or business: Farmer 7

MOTHER FATHER
12. Name: Not Known 7
13. Birthplace: " 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Not Known.
15. Birthplace: " (City, town, or county) (State or foreign country)

16. (a) Informant: Emil Brockmeyer
(b) Address: St Louis, Missouri

17. (a) Mosonia Cemetery (Burial, cremation, or removal) (b) Date thereof: Nov. 12. 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Mosonia St James

18. (a) Signature of funeral director: Jones & Herman
(b) Address: St James Mo.

19. (a) 12-1-40 (Date received local registrar) (b) Elsie B. Hauck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: November day: 11th year: 1940 hour: minute: M.

21. I hereby certify that I attended the deceased from October 21st 1914 to November 10, 1940 that I last saw him alive on November 8th 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic Pneumonia	5 days
Due to Manic depressive Psychosis	8 weeks
Due to Mitral regurgitation	5 years
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: C. V. Hammler (M. D. or other)
Address: St. James, Mo. Date signed: XI. 11. '40

(Licensed Embalmer's Statement on Reverse Side)

92 N

RECEIVED
District Health Officer No. 5,
District File Number 12401197
Date Filed

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 L. J. Jones, Registered Apprentice No. ....., working under my personal supervision.

Signed L. J. Jones

Licensed Embalmer No. 2379

P. O. Address Steelville, Mo

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.

S. No. 2B
—2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 435-13

Registration District No. 678 Primary Registration District No. 3904 Registrar's No.

1. PLACE OF DEATH:
(a) County Phelps
(b) ~~City or town~~ St James
(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)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (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.

3. (a) PRINT FULL NAME Conrad Sieber
3. (b) If veteran, name war
3. (c) Social Security No.

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

8. AGE: Years 77 Months 11 Days 8 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 10 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.
Immediate cause of death Bronchial Pneumonia
Due to Hypostatic Pneumonia
Due to Manic degenerative Psychosis
Due to Mitral regurgitation
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 42 W
Of autopsy

Duration

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature C W Hammler (M. D. ~~or other~~)
Address St. James Date signed 11-20-40

SUPPLEMENTARY

S-43513