

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

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

000
139

FILED

OCT 13 1943

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8738**

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Alexian Brothers Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 hrs. 0
(Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Lemay
(If outside city or town limits, write "RURAL")

(d) Street No. 106 Teddy ave.
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME George Sieker

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 1
year 1943 hour 10 minute 5 M.

21. I hereby certify that I attended the deceased from July 15
1943 to October 1, 1943
that I last saw him alive on Oct 1, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Hemoria Duration 4 days

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Theresa Sieker

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased October 22 1869
(Month) (Day) (Year)

Due to Chronic myeloid ?

Due to _____ ?

Other conditions Pneumonia, Erythema 10 days
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

73	11	9	hr. min.
----	----	---	----------

9. Birthplace St. Charles MO
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

PHYSICIAN

Major findings:
Of operations _____

Of autopsy as above

Underline the cause to which death should be charged statistically.

MOTHER FATHER {

11. Industry or business _____

12. Name William Sieker

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Theresa Sieker

(b) Address 106 Teddy ave. Lemay, Mo.

17. (a) Burial Lakewood Cometary
(Burial, cremation, or removal)

(b) Date thereof SEP
(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director C. Hoffmeister U.S.L.Co.

(b) Address 7814 S. Broadway

19. (a) OCT 2 1943 (b) J. F. Baedek
(Date received local registration) (Registrar's signature)

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 _____

23. Signature Edmund [unclear] (M. D. or other) M.D.

Address 3800 [unclear] Date signed 10/1/43

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.....

Paul A. Shanklin

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

working under my personal supervision.

Signed

Paul A. Shanklin

Licensed Embalmer No. *3472*

P. O. Address *781A 30th Avenue*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 8738

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Alexander Brothers Hoops
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME George Sieker
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 married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 73 Months 11 Days 1 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) _____ (b) Date thereof Oct-5-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Oct 19 1943

19. (a) Oct 19 1943 (b) J. F. Budeck
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct - day 1
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

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? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTAL COPY

30387