

FILED OCT 23 1945 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4123

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town J.C.  
(c) Name of hospital or institution: St. Mary's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 28 hrs. 36 min.  
(Specify whether  
In this community 1 same  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wagoner  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4427 Rainbow Blvd.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? — years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 6 year 1945  
hour 11 minute 57 P. M.

21. I hereby certify that I attended the deceased from 7:30 a.m.  
Oct. 5, 1945, to 11:30 p.m. Oct. 6, 1945;  
that I last saw her alive on Oct. 5, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death peritonitis  
Chang's foodborne  
in hotel.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 55

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) \_\_\_\_\_ (a) \_\_\_\_\_ (b) \_\_\_\_\_  
23. Signature J. M. D. (M. D. or other)  
Address 1103 2nd Date signed 10/7/45

3. (a) PRINT FULL NAME Deane Christine Sieber

3. (b) If veteran, name war — no 3. (c) Social Security No. none

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased 10 - 5 - 45  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
28 hr. 36 min.

9. Birthplace J.C. Mo. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation N.B.

11. Industry or business \_\_\_\_\_

12. Name Hennie Elmer Sieber

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

14. Maiden name Rosella M. Smasal

15. Birthplace Cole Camp Mo. 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rosella Sieber

(b) Address 4427 Rainbow Blvd. J.C. Kans.

17. (a) Removal (b) Date thereof 10/8/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cole Camp Mo

18. (a) Signature of funeral director J. M. D.

(b) Address 207 Linwood

19. (a) 10-7-45 (b) W. H. Holmes  
(Date received local registrar) (Registrar's signature)

**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 Charles M Quirk  
Licensed Embalmer No. 3774  
P. O. Address Kansas City, 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, fact should be so stated above.**