S. No. 2
OM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 3 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

34709

State File No.

Registration District No. 317 Primary Registration District No. 36076 Registrar's No. 2470

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Delord Ave, Maryland Heights (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether In this community 16 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. Delord Ave. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John Henry Sieckmann

3. (b) If veteran, name war No

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 Lorena

6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased Aug (Month) 19 (Day) 1866 (Year)

8. AGE: Years 79 Months 2 Days 6 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Lumber Sawman

11. Industry or business Retired

FATHER
12. Name John Sieckmann
13. Birthplace Germany (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Pauline Baker

(b) Address 3502 South Jefferson

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 (Month) 29 (Day) 45 (Year)

(c) Place: burial or cremation St. Johns Cemetery

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Ave.

19. (a) 10-27-45 (Date received local registrar) (b) E. G. McGovran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25 year 45 hour 9 minute P- M.

21. I hereby certify that I attended the deceased from June 19, 1942, to Oct 25, 1945; that I last saw him alive on Oct 25, 1945, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

930

Due to

Due to Arteriosclerosis Apoplexy 1942

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Royal C. McLean M.D. (M.D. or other)

Address Kirkwood Mo. Date signed 10-26-45

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.