

No. 2  
 FORM-5-43  
 Rev. 5-17-39  
 I X38671

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 36392  
 Registrar's No. 4705

**FILED** NOV 26 1945  
 Registration District No. 1002

Primary Registration District No. 1002

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

**1. PLACE OF DEATH:**  
 (a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
None 2020 Cypress  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution None  
(Specify whether years, months or days)  
 In this community 20 Years

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2020 Cypress  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Louis R. Sieggen  
 3. (b) If veteran, name war No  
 3. (c) Social Security No. 486-01-8100

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month 11 day 12  
 year 1945 hour 11:35 minute 0 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.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Emma B. Sieggen  
 6. (c) Age of husband or wife if alive 47 years  
 7. Birth date of deceased Oct. 29th, 1903  
(Month) (Day) (Year)

Immediate cause of death Brainy rupture  
 Due to arteriosclerosis  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE:	Years	Months	Days	If less than one day
	<u>42</u>	<u>0</u>	<u>13</u>	hr. _____ min. _____

9. Birthplace Ill.  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Refrigeration refrigeration  
 11. Industry or business Repair Service  
 12. Name Louis D. Sieggen  
 13. Birthplace Ill.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Anna Tusheck  
 15. Birthplace Ill.  
(City, town, or county) (State or foreign country)

Major findings:  
 1. Of operations \_\_\_\_\_  
 Of autopsy no  
History + Inspection  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Emma B. Sieggen  
 (b) Address 2020 Cypress Ave.  
 17. (a) Burial (b) Date thereof 11/14/45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Elmwood Cem.  
 18. (a) Signature of funeral director Earp Funeral Home  
 (b) Address 4139 East 15th, St.  
 19. (a) 11-14-45 (b) Staldine Holmes  
(Date received local registrar) (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?  
(Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury 3  
 23. Signature J. J. ... (M. D. or other) \_\_\_\_\_  
 Address 1429 ... Date signed 11-17-45

---

---

**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

*John B. Cox*  
.....  
Licensed Embalmer No. *2455*  
.....  
P. O. Address *F.C. Spivey*  
.....

**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.**