DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18894

FILED MAY 17 1946

Registration District No. ____ Primary Registration District No. 1003 Registrar's No. 4113

1. PLACE OF DEATH:

(a) County ____

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

(c) Name of hospital or institution: 3203 Russell Blvd (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 Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ____

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 3203 Russell Blvd (If rural, give location)

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

If yes, name country ____

3. (a) PRINT FULL NAME Clifford Edward Seiferth

3. (b) If veteran, name war World War #1

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 Vernal

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased October (Month) 12 (Day) 1895 (Year)

8. AGE: Years 50 Months 6 Days 23 If less than one day ____ hr. ____ min.

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

10. Usual occupation Manager

11. Industry or business Smiley Inc.

FATHER

12. Name Edward M. Seiferth

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

MOTHER

14. Maiden name Nellie Noslage

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

16. (a) Informant Mrs Vernal Seiferth Wife

(b) Address 3203 Russell Blvd

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7th 1946 (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Peetz Funeral Home

(b) Address 3029 Lafayette Ave

19. (a) MAY 6 1946 (Date received local registrar) (b) J. F. Breneck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5th year 1946 hour 11:45 minute P M.

21. I hereby certify that I attended the deceased from Oct. 16, 1944, to May 5, 1946 that I last saw him alive on May 4, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Liposarcoma	1½ yrs
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Anthony B. Clay (M. D. or other)

Address 3720 Washington Date signed 5-6-46

(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 Frank E Dunn

Licensed Embalmer No. 2245

P. O. Address 27 Lowell Ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4113

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis
(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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Clifford E. Leibeth

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 Oct (Month) 12 (Day) (Year)

8. AGE: Years 50 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Mo
(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 January Day 5 year 1946 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.

	Duration
Immediate cause of death Lymphosarcoma axillary & cervical glands originally; later becoming generalized (Lymphatic glands & lungs)	
Due to	
Due to	
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 Anthony B. Day (M. D. or other) M.D.

Address Date signed

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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