

FILED JUL 26 1946
318

1003

Registration District No. _____ Primary Registration District No. _____

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

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: DePaul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Arlene Siesener

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Lambert O. Siesener

6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased September 26, 1909
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>36</u>	<u>9</u>	<u>19</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Aloys Eufinger

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

14. Maiden name Helen Kobinska

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

16. (a) Informant Lambert O. Siesener

(b) Address 1606 McLaren

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

(b) Date thereof July 18 '46
(Month) (Day) (Year)

(c) Place: burial or cremation Sacred Heart Cemetery
Bromschwig Funeral Home

18. (a) Signature of funeral director _____

(b) Address 4746 W. Florissant Ave.

19. (a) JUL 16 1946
(Date received local registrar)

(b) [Signature]
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
17

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

(d) Street No. 1606 McLaren
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15
year 1946 hour 40 minute 05 a.m.

21. I hereby certify that I attended the deceased from July 13
1946 to July 15, 1946
that I last saw her alive on July 15, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Shock Duration 5 hrs

Due to Ablatio placenta 5 hrs

Death during delivery Eclampsia, severe 48 hrs

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: apoplexy uterus

Of autopsy none done

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? _____

23. Signature Roy V. Bauder (M. D. or other) M.D.
4500 Olive St. Date signed July 16 1946

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

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..... *W. Wilkinson*

Licensed Embalmer No..... *3575*

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.