

No. 2
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-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 30 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30807**

Registration District No. **164**

Primary Registration District No. **8032**

Registrar's No. **84**

1. PLACE OF DEATH:
 (a) County: **Johnson**
 (b) City or town: **Warrensburg**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Clinic**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **12 hours**
(Specify whether years, months or days)
 In this community **20 years**

2. USUAL RESIDENCE OF DECEASED:
 (a) State: **Mo** (b) County: **Johnson**
 (c) City or town: **Knob Noster**
(If outside city or town limits, write "RURAL")
 (d) Street No.: **0**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country: _____

3. (a) PRINT FULL NAME **GEO. HIRAM SIEGFRIED**

3. (b) If veteran, name and war: **486-26-1536**
3. (c) Social Security number: _____

4. Sex: **male** **5. Color of race:** **white**
6. (a) Single, widowed, married, divorced: **widowed**

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

7. Birth date of deceased: **Sept-26-1886**
(Month) (Day) (Year)

8. AGE: Years **59** Months **11** Days **17**
If less than one day hr. min.

9. Birthplace: **Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Carpenter**

11. Industry or business: _____

12. Name: **John Siegfried**

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: **Hannon Siegfried**
(b) Address: **Knob Noster Mo**

17. (a) Burial: **Burial** **(b) Date thereof:** **Sept-11-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: **City Cem. Kn. Mo**

18. (a) Signature of funeral director: **R. L. Sauls**
(b) Address: **Knob Noster Mo**

19. (a) Date received local registrar: **Sept. 14 46** **(b) Registrar's signature:** **Sarannah Overholt**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **13**
 year **1946** hour **3** minute **45 A.M.**

21. I hereby certify that I attended the deceased from: **Sept 12** 19**46** to **Sept 13** 19**46**
 that I last saw him **alive** on **Sept 12** 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Cerebral hemorrhage**
 Due to: **Hypertension et arterio sclerosis**
 Due to: _____

Duration
16 days
indefinite

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations: _____
 Of autopsy: **83P**

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: _____
 Signature: **J. Reed Mason** (M. D. or other) _____
 Address: **Warrensburg** Date signed: **Sept 14**

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

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WINTER MAXI

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 C. L. Sauls
....., Registered Apprentice No.
working under my personal supervision.

Signed C. L. Sauls
Licensed Embalmer No. 1086
P. O. Address Knob Noster Md

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.