

FILED FEB 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6691  
Registrar's No. 1480

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>74 years</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		17	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Christian Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>1521 E. Grand</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Harry</b>		b. (Middle) _____		c. (Last) <b>Sieckmann</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 14, 1949</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>March 29, 1874</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pop Corn</b>		11. BIRTHPLACE (State or foreign country) <b>St. Louis Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Frederick Sieckmann</b>			13b. MOTHER'S MAIDEN NAME <b>Louisa Sterner</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Lottie Schewe Sieckmann</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. K.S. Kropel 2034 Adelaide</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Post-operative shock</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Incarcerated, Umbilical hernia</b> DUE TO (c) <b>17 1/2 5 1/2 5</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>4-8 hrs.</b>  <b>124 hrs.</b>	
19a. DATE OF OPERATION <b>2-12-49</b>		19b. MAJOR FINDINGS OF OPERATION <b>Umbilical herniectomy, Incarceration small intestine</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan. 15, 1949</b> , to <b>Feb. 14, 1949</b> , that I last saw the deceased alive on <b>Feb. 14, 1949</b> , and that death occurred at <b>4:45 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>J.E. Joffe M.D.</b>				23b. ADDRESS <b>4222 N. Grand</b>		23c. DATE SIGNED <b>2-15-49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Feb. 17, 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>New Bethlehem Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>	
DATE REC'D BY LOCAL REG. <b>FEB 19 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Lasater</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Beiderwieden F. Home Inc. 1936 St. Louis Ave.</b>			

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

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Walter Paulson

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4114

P. O. Address 1936 5th St. S. De

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.