

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21683**  
**5746**  
Registrar's No.

FILED JUL 15 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_ 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
a. STATE **Missouri** b. COUNTY **Can**

b. CITY (If outside corporate limits, write RURAL and give township) c. LENGTH OF STAY (In this place) c. CITY (If outside corporate limits, write RURAL and give township)  
OR TOWN **St. Louis** **0** OR TOWN **St. Louis** **17**

d. FULL NAME OF HOSPITAL OR INSTITUTION **Jewish Hospital** d. STREET ADDRESS (If rural, give location)  
**5656 Waterman Ave.**

3. NAME OF DECEASED a. (First) b. (Middle) c. (Last) 4. DATE OF DEATH (Month) (Day) (Year)  
**BESS** **SIEVERS** **July 2, 1949**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married** 8. DATE OF BIRTH **Oct. 2, 1882** 9. AGE (In years last birthday) **66** IF UNDER 1 YEAR Months **9** Days **-** IF UNDER 24 HRS. Hours **-** Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **At home** 10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_ 11. BIRTHPLACE (State or foreign country) **St. Louis, Mo.** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

13a. FATHER'S NAME **Marcus H. Brown** 13b. MOTHER'S MAIDEN NAME **Unknown** 14. NAME OF HUSBAND OR WIFE **Charles S. Sievers, Sr.**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) \_\_\_\_\_ 16. SOCIAL SECURITY NO. \_\_\_\_\_ 17. INFORMANT'S SIGNATURE OR NAME **Charles S. Sievers, Sr.** ADDRESS **5656 Waterman Ave.**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH  
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **Myocarditis chronic** **Several years**  
\*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. ANTECEDENT CAUSES DUE TO (b) **Auricular Fibrillation** **1 1/2 yrs.**  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) **Embolic lung pt.**  
II. OTHER SIGNIFICANT CONDITIONS **arteriosclerosis**  
Conditions contributing to the death but not related to the disease or condition causing death. **Hypertension**

19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES  NO

21a. ACCIDENT (Specify) \_\_\_\_\_ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) **932** (STATE) **MO**

21d. TIME OF INJURY ~~0800~~ **12:00** (Month) (Day) (Year) (Hour) \_\_\_\_\_ 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? **4-500**

22. I hereby certify that I attended the deceased from **July 1, 1949**, to **July 2, 1949**, that I last saw the deceased alive on **July 1, 1949**, and that death occurred at **2:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE **Edw. F. Sievers** (Degree or title) **M.D.** 23b. ADDRESS **634 N. Grand Ave** 23c. DATE SIGNED **7/2/49**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **7-4-49** 24c. NAME OF CEMETERY OR CREMATORY **Mt. Olive Cemetery** 24d. LOCATION (City, town, or county) (State) **St. Louis County, Mo.**

DATE REC'D BY LOCAL REG. **JUL 3 1949** REGISTRAR'S SIGNATURE **J. B. Laster** 25. FUNERAL DIRECTOR'S SIGNATURE **Herman Rudolph, Inc.** ADDRESS **5216 Delmar**

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.....

.....  
working under my personal supervision.

Student .....  
Student Embalmer

Student Embalmer No. ....  
Signed *J. L. Ketter* .....  
Licensed Embalmer No. *3880* .....  
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.