

FILED NOV 13 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

36086

5055

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>70 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Shea Nursing Home</u>				* STREET ADDRESS (If rural, give location) <u>6833 College</u> <u>14</u> <u>3888</u> <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>CLARA</u>		b. (Middle) <u>MARGARET</u>		c. (Last) <u>SIEVERS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10</u> <u>21</u> <u>53</u>	
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>8-11-1878</u>	
9. AGE (In years last birthday) <u>75</u>		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) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>XX</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>No Record</u>		13b. MOTHER'S MAIDEN NAME <u>No Record</u>		14. NAME OF HUSBAND OR WIFE <u>John D. Sievers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>XX</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Louise Sievers, 6833 College, KC Mo.</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANCECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterial Hypertension</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Cerebral Hemorrhage</u> Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension Heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10/19/52</u> <u>20 years</u> <u>7/21/53</u> <u>2 years</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) <u>331X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		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 <u>5/5</u> , 19 <u>52</u> , to <u>10/20</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>10/20</u> , 19 <u>53</u> , and that death occurred at <u>5:30 Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>R. R. Becker</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>4000 Baltimore Ave. Kansas City, Mo</u>		23c. DATE SIGNED <u>10/21/53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-23-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>	
DATE REC'D BY LOCAL REG. <u>10-22-53</u>		REGISTRAR'S SIGNATURE <u>Seraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Wagner</u>		ADDRESS <u>K C Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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..

Student.....
Signature of Student Embalmer

Signed *Alvin R. Hainisch*.....

Licensed Embalmer No. *415*.....

P. O. Address *K. C.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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