

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

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**37601**

FILED OCT 30 1953

State File No. ....

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **10193**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		State File No. ....		Registrar's No. <b>10193</b>			
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)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		2199					
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4123 Lafayette Ave.</b>				d. STREET ADDRESS (If rural, give location) <b>4123 Lafayette Ave.</b>							
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Eugene</b>		b. (Middle) <b>J.</b>		c. (Last) <b>Siempelkamp</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>10/26/53</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>May 31 1884</b>		9. AGE (In years last birthday) <b>69</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self. Emp.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Organ Maker</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13a. FATHER'S NAME <b>John Siempelkamp</b>			13b. MOTHER'S MAIDEN NAME <b>unk</b>			14. NAME OF HUSBAND OR WIFE <b>Alice Siempelkamp</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>493-05-4513</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Alice Siemplekamp</b> ADDRESS <b>4123 Lafayette Ave.</b>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				<b>MEDICAL CERTIFICATION</b>				INTERVAL BETWEEN ONSET AND DEATH			
<p><i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i></p> <p><b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral apoplexy</b></b></p> <p><b>ANTECEDENT CAUSES</b></p> <p><i>Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last.</i></p> <p><b>DUE TO (b) <b>Achylia gastrica</b></b></p> <p><b>DUE TO (c) <b>Arteriosclerosis</b></b></p> <p><b>II. OTHER SIGNIFICANT CONDITIONS</b></p> <p><i>Conditions contributing to the death but not related to the disease or condition causing death.</i></p>								<b>one hour</b>			
								<b>9 years</b>			
								<b>2 years</b>			
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)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>334X</b>							
22. I hereby certify that I attended the deceased from <b>February, 19 44</b> , to death, 19____, that I last saw the deceased alive on <b>Oct. 23, 19 53</b> , and that death occurred at <b>8:00a m.</b> , from the causes and on the date stated above.											
23a. SIGNATURE <b>A.R. Finney M.D.</b> (Degree or title)				23b. ADDRESS <b>539 No. Grand Blvd.</b>				23c. DATE SIGNED <b>10/26/53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>10/29/53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>					
DATE REC'D BY LOCAL REG. <b>OCT 27 1953</b>		REGISTRAR'S SIGNATURE <b>Carl Smith MO</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. W. Clark</b> ADDRESS <b>1125 Hodiamont Ave.</b>						

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 Embalmer No. ....

Signed

*Alfred J. Brodeur*

Signed.....  
Student Embalmer

Licensed Embalmer No. 2163

P. O. Address 1123 Hodson

Note: The above MUST, BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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