

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **4323**

FILED MAR 15 1954

BIRTH NO. _____ REG. DIST. NO. **73** PRIMARY REG. DIST. NO. **5291** Registrar's No. **212**

1. PLACE OF DEATH a. COUNTY CLAY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY RAY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL LIBERTY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL EXCELSIOR SPRINGS	
c. LENGTH OF STAY (In this place) 16 days		d. STREET ADDRESS (If rural, give location) R 2, Excelsior Springs	
d. FULL NAME OF HOSPITAL OR INSTITUTION IOOF HOSPITAL		4. DATE OF DEATH (Month) (Day) (Year) MAR 6, 1954	
3. NAME OF DECEASED (Type or Print) a. (First) HENRY b. (Middle) SIEGEL c. (Last)		5. SEX MALE 6. COLOR OR RACE WHITE	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH MAR. 29, 1872	
9. AGE (In years last birthday) 81 Months 11 Days 7		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (City and State or Foreign Country) Excelsior Springs, Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME unknown	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME IOOF HOSP. RECORDS		ADDRESS Rural Liberty	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) CONGESTIVE HEART FAILURE		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure			
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.			
ANTECEDENT CAUSES DUE TO (b) Arteriosclerosis			
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4500	
20. AUTOPSY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
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 Feb 20 , 19 53 , to _____, 19____, that I last saw the deceased alive on Mar 4 , 19 54 , and that death occurred at 7:55 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE Wm J Gadsden (Degree or title) Chap.		23b. ADDRESS Liberty Mo	
23c. DATE SIGNED 2/6/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar 6/54	
24c. NAME OF CEMETERY OR CREMATORY SIEGEL Cemetery		24d. LOCATION (City, town, or county) (State) Excelsior Springs Ray, Mo	
DATE REC'D BY LOCAL REG. March 9, 1954		REGISTRAR'S SIGNATURE Mabel Strahan 491	
25. FUNERAL DIRECTOR'S SIGNATURE Hope Funeral Home		ADDRESS Excelsior Springs, Mo	

6000

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
Student Embalmer

Signed Chas. Virgil Hope

Licensed Embalmer No. 3950

P. O. Address Epelsior Springs

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.