

FILED MAY 20 1957

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

State File No. **19293**
3666

BIRTH NO. **35531-57** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3666**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St Louis			
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN Florissant d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Louis Maternity e. STREET ADDRESS (If rural, give location) 27 Teson Road R R #3 Box 397					
3. NAME OF DECEASED (Type or Print) a. (First) Infant b. (Middle)			c. (Last) Siegler		4. DATE OF DEATH (Month) (Day) (Year) April 1 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) --		8. DATE OF BIRTH April 1 1957	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 2 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Missouri	

13a. FATHER'S NAME Kenneth Joseph Siegler		13b. MOTHER'S MAIDEN NAME Kathleen LaVerne Aubuchon		14. NAME OF HUSBAND OR WIFE --	
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 ADDRESS Kathleen LaVerne Siegler	

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2.55"
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) atelectasis of lungs		
	ANTECEDENT CAUSES DUE TO (b) prematurity DUE TO (c) 762.5		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. intraventricular hemorrhage			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20) AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 **April 1, 1957**, to **April 1, 1957**, that I last saw the deceased alive on **April 1, 1957**, and that death occurred at **4:30 P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Seymour Momet, M.D.	23b. ADDRESS 15 no. Brentwood	23c. DATE SIGNED 4-10-57
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 4-30-57	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		

DATE REC'D BY LOCAL REG. APR 17 '57	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland - aka / 4404 Manchester
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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.....

Licensed Embalmer No.....

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

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