

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. **38155**

FILED NOV 15 1957

318**1003****10617**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10617	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis, Mo.		c. LENGTH OF STAY (If in this place) 4 Mo. 18 Days		c. CITY OR TOWN St. Louis,		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 St. Louis Chronic Hospital.				• STREET ADDRESS (If rural, give location) 4338 College,			
3. NAME OF DECEASED (Type or Print) a. (First) Carrie		b. (Middle) _____		c. (Last) Sieckmann		4. DATE OF DEATH (Month) (Day) (Year) November 5--1957.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Dec. 24, 1879		9. AGE (In years last birthday) 77	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo..		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Niemeyer.		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND/OR WIFE William Sieckmann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 498-01-4013		17. INFORMANT'S SIGNATURE OR NAME Florence Sieckmann ADDRESS 2309 Salisbury			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sept. Mid. Cerebral Art. Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Decubitus Sacro-Iliac Area				INTERVAL BETWEEN ONSET AND DEATH 6 days. 5 mo. 5 mo. 2 days.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPOST? 332x 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) _____ m. _____		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 June 18, 1957 to November 5, 1957 , that I last saw the deceased alive on Nov. 5, 1957 , and that death occurred at 12:15 P.M. on the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) John W. Beckham, M.D.				23b. ADDRESS 5800 Arsenal		23c. DATE SIGNED 11/6/57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/8/57	24c. NAME OF CEMETERY OR CREMATORY Bethlehem Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.		
DATE REC'D BY LOCAL REG. NOV 8 57		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Morrell ADDRESS 3710 N. Grand Blvd			

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 *Robert M. Murray*
Licensed Embalmer No. *3749*

P. O. Address *St. Louis*

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.