

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3581

STATE FILE NUMBER

FILED FEB 6 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1141

300

1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3815 Federer Pl.		d. STREET ADDRESS (If outside, give location) 3815 Federer Pl.	
3. NAME OF DECEASED (Type or print) First MARY Middle Last SEIBEL		4. DATE OF DEATH Month Jan. Day 30 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sep. 3, 1857
9. AGE (In years last birthday) 100		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	11. BIRTHPLACE (City and state or country) Centreville, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John Mayer	13b. MOTHER'S MAIDEN NAME Margaret Moellenkopf
14. NAME OF HUSBAND OR WIFE Late Phillip Seibel		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give name or dates of service) No	16. SOCIAL SECURITY NO. 500-18-6568
17. INFORMANT Conrad C. Seibel		Address 3802 Hartford St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease 5 yrs DUE TO (b) Generalized Arterio Sclerosis 20 yrs DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 420.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1930 to Jan 30/58 and last saw her alive on Jan 29/58 Death occurred at 3:00 P. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) W. A. Oshy, M.D.	
22b. ADDRESS 4724 Travels		22c. DATE SIGNED 1/30/58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Feb. 1, 1958	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR Kriegshauser		25. DATE RECD. BY LOCAL REG. JAN 30 '58	
ADDRESS 4228 S. Kingshighway		26. REGISTRAR'S SIGNATURE J. Carl Smith M.D. m83	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with be listed. All diseases in Part I must be causally related.

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 *William B. White*

Licensed Embalmer No. *4291*

P. O. Address *4220 S. ...*

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.