

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027436

STATE FILE NUMBER

FILED AUG 6 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7322

300  
1-57

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, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>4627 Bessie Avenue,</b>	
Length of stay in lb <b>2 7/8</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROYAL WILLIAM SIEFERT</b>			4. DATE OF DEATH Month Day Year <b>JULY 24, 1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> (DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 14th, 1893</b>
9. AGE (In years last birthday) <b>64</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern &amp; Restaurant</b>	
11. BIRTHPLACE (City and state or country) <b>Hot Springs, Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Jacob F. Siefert</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Kenison</b>	
14. NAME OF HUSBAND OR WIFE <b>Florence Siefert</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>	
16. SOCIAL SECURITY NO. <b>493-38-1219</b>		17. INFORMANT Address <b>Florence Siefert, 4627 Bessie Avenue, 15,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>SQUAMOUS CELL CARCINOMA OF ALVEOLAR RIDGE</b>			<b>1 YEAR</b>
DUE TO (c)			
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 checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 WORK <input type="checkbox"/> 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 <b>JULY 21, 1958</b> to <b>JULY 24, 1958</b> and last saw her/him alive on <b>JULY 24, 1958</b> Death occurred at <b>1:10 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Print name or title) <i>C. P. Vermillion, M.D.</i>		22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>7/25/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/28/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or country) (State) <b>St. Louis, Missouri</b>
24. EMBALMER'S NAME AND ADDRESS <b>CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., FURNACE HOME, INC., St. Louis, 15, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 26 '58</b>	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> <b>S.P.</b>

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Ralph C. Lindner* .....

Licensed Embalmer No. *4225* .....

P. O. Address *St. Louis, Mo.* .....

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.