

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038219

State File No.

FILED OCT 20 1958

BIRTH NO. 60365-58 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8964

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS, MO. (15)</u>		c. CITY OR TOWN <u>ST. LOUIS 121</u>	
c. LENGTH OF STAY (In this place) <u>13 hrs - 5 min</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) <u>17 CHRISTIAN HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>27 10109 CROWN POINT</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>BABY</u> b. (Middle) <u>SIECK MANN</u> c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>8 - 11 - 58</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>INFANT 0</u>	8. DATE OF BIRTH <u>8 - 10 - 58</u> ✓
9. AGE (In years last birthday)		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)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>ST. LOUIS, MO - 0</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			

13a. FATHER'S NAME <u>WILLIAM WALTER SIECKMANN</u>	13b. MOTHER'S MAIDEN NAME <u>BOANNE ELIZABETH EADS</u>	14. NAME OF HUSBAND OR WIFE
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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 <u>X Mrs Wm Sieckmann</u>	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>13 hrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prematurity, 20 week gestation</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b)		
	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	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input 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) <u>776x</u>

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Aug 10, 1958, to Aug 11, 1958, that I last saw the deceased alive on Aug 11, 1958, and that death occurred at 9:50A m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u>	(Degree or title) <u>MD</u>	23b. ADDRESS <u>4222 N. Grand</u>	23c. DATE SIGNED <u>8-12-58</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>9-30-58</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>SEP 17 '58</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>4104 Manchester</u>
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(Licensed Embalmer's Statement on Reverse Side)

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.