

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007639

STATE FILE NUMBER

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FILED FEB 17 1959 Registration District No. Primary Registration District No. Registrar

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Illinois</b> b. COUNTY <b>Piatt</b>                    |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>ST. LOUIS, MISSOURI</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY<br>OR<br>TOWN <b>White Heath</b>   |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <b>BARNES HOSPITAL</b>  |   | Length of stay in 1b  | d. STREET<br>ADDRESS (If outside, give location)   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Lyda</b><br><del>ELLA</del><br>Middle <b>Ella</b><br><del>MAYNE</del><br>Last <b>SIEVERS</b>   |   | 4. DATE<br>OF<br>DEATH <b>JANUARY 30, 1959</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>1890</b><br><b>April 5, 1889</b>   |
| 9. AGE (In years<br>last birthdgy) <b>59 68</b>   |   | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR<br>INDUSTRY  | 11. BIRTHPLACE (City and state or country)<br><b>Waterloo, Ky.</b>                                   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   | 13a. FATHER'S NAME<br><b>Lincoln Weddle</b>   |  |
| 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>W.N. Sievers</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  | 17. INFORMANT<br>Address<br><b>Arnold Sievers, Monticello, Ill.</b>                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHIECTASIS</b>   |   |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>MANY YEARS</b>   |
| Conditions, if any,<br>which gave rise to<br>above cause (a),<br>stating the under-<br>lying cause test. }<br>DUE TO (b) <b>PULMONARY EMPHYSEMA WITH FIBROSIS</b>   |   |   | <b>MANY YEARS</b>  |
| DUE TO (c) <b>527.1</b>   |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |   |   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury, date, time, place, etc.)<br>ITEM <b>3, 2, 7</b> CORRECTED                                       |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m.<br>p.m.  |   | BY: 1. AFFIDAVIT OF Informant<br>2. DOCUMENT <b>State Mutual Ins. Policy # 338473 dated 4-10-1918</b>   |  |
| 20d. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> NOT WHILE<br>WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 20e. PLACE OF INJURY (e.g., in or about home,<br>farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION  | COUNTY STATE   |
| 21. I attended the deceased from <b>JAN. 16, 1959</b> to <b>JAN. 30, 1959</b> and last saw her alive on <b>JAN. 30, 1959</b><br>Death occurred at <b>8:15 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |   |   |  |
| 22a. SIGNATURE<br><b>C. P. Vermillion, M.D.</b> (Degree or title)   |   | 22b. ADDRESS<br><b>BARNES HOSPITAL</b>  | 22c. DATE SIGNED<br><b>1/31/59</b>   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Removal</b>  | 23b. DATE<br><b>2-2-59</b>  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION (City, town, or county)<br><b>Monticello, Ill.</b> (State)                             |
| 24. FUNERAL DIRECTOR<br><b>Albert H. Hoppe, 4700 Washington Blvd.</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>FEB 2 59</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith, M.D.</b>   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 ..... *John S. Dunne*

Licensed Embalmer No. 4199

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.