

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024815

FILED VS AUG 17 1959 **28**

Registration District No. **2000** Primary Registration District No. **2000** Registrar's No. **831A**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <input checked="" type="checkbox"/> Texas b. COUNTY Dallas	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield, Missouri	Length of stay in 1b 21 Hours	c. CITY OR TOWN Dallas	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5701 W. Claridge Drive

3. NAME OF DECEASED (Type or print) First MARY Middle LEA Last SIEVING			4. DATE OF DEATH Month August Day 2 Year 1959		
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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 1/6/1933	9. AGE (last birthday) 26	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer	10b. KIND OF BUSINESS OR INDUSTRY Transistors	11. BIRTHPLACE (City and state or country) Koshonong, Missouri	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME William Hurst	13b. MOTHER'S MAIDEN NAME Mary Perkins	14. NAME OF HUSBAND OR WIFE Robert Walter Sieving
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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) No	16. SOCIAL SECURITY NO. 196-34-6916	17. INFORMANT Mr. Harry F. Sieving, St. Louis 21, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Mutiple Pulmonary Infarct		
Crushing Chest Injury		
Acute Pulmonary Edema		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) Multiple Fractures Auto Accident		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Auto Accident 1 August 1959
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20c. TIME OF INJURY Hour 11:30Am a.m. 8-1-1959 Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway #166	20f. CITY, TOWN, OR LOCATION 3 mi. West Republic	COUNTY Greene	STATE Mo.
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21. I attended the deceased from **1 August 1959** to **2 August 1959** and last saw her/him alive on **2 August 1959**
 Death occurred at **Springfield, Missouri 8:50 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>James E. Johnson</i> (Degree or title) M.D.	22b. ADDRESS Springfield, Mo.	22c. DATE SIGNED 7 Aug 59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE August 5, 1959	23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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24. FUNERAL DIRECTOR ADDRESS Beiderwieden F.H.Inc., 1936 St. Louis	25. DATE RECD. BY LOCAL REG. 8-10-59	26. REGISTRAR'S SIGNATURE <i>Effie E. Melton</i>
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(Licensed Embelmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 28 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William B. Conner

Licensed Embalmer No. 4820

P. O. Address Republic

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.