

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-024816**

STATE FILE NUMBER

FILED VS. AUG. 17 1959

Registration District No. 2000 Registrar's No. 821

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Greene</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Texas</u> b. COUNTY <u>Dallas</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Springfield, Missouri</u>		Length of stay in 1b <u>1 hour</u>	c. CITY OR TOWN <u>Dallas</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5701 W. Claridge Circle</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ROBERT</u> Middle <u>WALTER</u> Last <u>SIEVING</u>			<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>1</u> Year <u>1959</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3/3/1929</u>	<b>9. AGE (last birthday)</b> <u>30</u>	<b>IF UNDER 1 YEAR</b> Months <u>    </u> Days <u>    </u> Hours <u>    </u> Min. <u>    </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Metal Products Co.</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>St. Louis, Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>	
<b>13a. FATHER'S NAME</b> <u>Harry F. Sieving</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Vera E. Welp</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Mrs. Mary Lea Sieving</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Korean War</u>		<b>16. SOCIAL SECURITY NO.</b> <u>500-26-1013</u>	<b>17. INFORMANT</b> Address <u>Mr. Harry F. Sieving, 3091 Bellerive Dr. St. Louis 21, Mo.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> DUE TO (b) <u>Cerebral edema</u> DUE TO (c) <u>Extensive cerebral trauma - closed injury</u> 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 type="checkbox"/> No <input type="checkbox"/> Unknown					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <u>ovr</u>				
<b>20c. TIME OF INJURY</b> Hour <u>    </u> a.m. <u>    </u> p.m.	Month, Day, Year	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	COUNTY STATE	
<b>21. I attended the deceased from</b> <u>Aug 1, 1959</u> <b>to</b> <u>8-1-59</u> <b>and last saw her/him alive on</b> <u>8-1-59</u> Death occurred at <u>12:55 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> (Type or print) <u>F. Thomas Moseley, M.D.</u>			<b>22b. ADDRESS</b> <u>1636 South Glenstone Springfield, Missouri</u>		<b>22c. DATE SIGNED</b> <u>8/8/59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>	<b>23b. DATE</b> <u>August 5, 1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Trinity Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) <u>St. Louis County, Missouri.</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Beiderwieden F. H. Inc. 1936 St. Louis</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>8-10-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Effie S. Meeton</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 17 1959

AUG 26 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. Coulter*

Licensed Embalmer No. 482

P. O. Address Republic

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.