

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027190

FILED VS JUL 24 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 6471** STATE FILE NUMBER

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</b>	Length of stay in 1b <b>4 hours</b>	c. CITY OR TOWN <b>St. Louis</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4265 Fair Avenue</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>W</b> Last <b>Seipp</b>			4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>1959</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>11-2-1900</b>	9. AGE (last birthday) <b>58</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe Fitter (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laclede Gas Company</b>		11. BIRTHPLACE (City and state or country) <b>Kimmswick, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>William Seipp</b>		13b. MOTHER'S MAIDEN NAME <b>Minnie Roth</b>		14. NAME OF HUSBAND OR WIFE <b>Elizabeth</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>492-03-6920</b>		17. INFORMANT Address <b>Elizabeth Seipp, 4265 Fair Avenue</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>Mureatic Acid poisoning</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	<b>971.8</b>

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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Self ingested in basement</b>	
20c. TIME OF INJURY Hour <b>7:59</b> a.m. p.m. Month, Day, Year <b>of Home on about July 7, 1959.</b>	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.) <b>Home</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>St. Louis Mo</b>
21. I attended the deceased from <b>340 P.</b> to <b>per</b> and last saw her <b>alive</b> on <b>the date stated above, and to the best of my knowledge, from the causes stated.</b>			

22a. SIGNATURE (Degree or title) <b>Joseph M. Hermann Deputy</b>		22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>7/9/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 11, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Math Hermann &amp; Son, Inc., 2161 E. Fair Av</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 9 '59</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

EX-AFFIDAVIT OF

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 Welford G Bessie

Licensed Embalmer No. 4202

P. O. Address St Louis

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