

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

**59-027604**

FILED VS AUG 10 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2003

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves</u> Length of stay in 1b <u>MONS.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Glenwood Sanitarium</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>Webster Groves</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1414 Wexford</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Jacob</u> Middle <u>F</u> Last <u>Siefert</u>			<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>25</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 type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>11-3-1871</u>	<b>9. AGE</b> (last birthday) <u>87</u>	<b>IF UNDER 1 YEAR</b> Months <u>    </u> Days <u>    </u>	<b>IF UNDER 24 HR</b> 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>Train Director</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Terminal RR</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Belleville, Ill</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>
<b>13a. FATHER'S NAME</b> <u>Unk <del>Jacob</del> FREDERICH SIEFERT</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Unk ELIZABETH BISHOP</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Mary B. Siefert</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>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unk.</u>	<b>17. INFORMANT</b> Address <u>Marguerite Sauter 1414 Wexford</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>Myocardial infarction</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pyelonephritis, Pneumonia</u>					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	
<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.)				
<b>20c. TIME OF INJURY</b> Hour _____ Month, Day, Year _____ a.m. _____ p.m.		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" 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>		<b>COUNTY</b>	<b>STATE</b>	
<b>21. I attended the deceased from</b> <u>3-59</u> to <u>7-25-59</u> and last saw her/him alive on <u>7-25-59</u> Death occurred at <u>5:45</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> (Degree or title) <u>Thomas T. Flynn MD</u>			<b>22b. ADDRESS</b> <u>1300 Grant Rd.</u>		<b>22c. DATE SIGNED</b> <u>7-26-59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>	<b>23b. DATE</b> <u>7-29-59</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Resurrection</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>St. Louis Co. Mo.</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>M.J. Croghan 831 E. Big Bend</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-27-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>John C. Murphy M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY 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 Lustan W. Dieter

Licensed Embalmer No. 432  
P. O. Address H. Lavin

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.