JRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS FEB 18 1960

2 1084 — [redacted]

STATE FILE NUMBER 60-008878

ENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b: D.O.A.

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Christian Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY

c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 4223 Red Bud Avenue — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Herman — Middle: F — Last: Sieckman

4. DATE OF DEATH: Month: January — Day: 29 — Year: 1960

5. SEX: male

6. COLOR OR RACE: white

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 9-21-1880

9. AGE (last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer - Retired

10b. KIND OF BUSINESS OR INDUSTRY: Hoffmann Grocer Co

11. BIRTHPLACE (City and state or country): Charlotte, Missouri

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: William Sieckman

13b. MOTHER'S MAIDEN NAME: Mary Holekamp

14. NAME OF HUSBAND OR WIFE: Martha F. Sieckman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 497-03-4378A

17. INFORMANT: Mrs. Martha F. Sieckman, 4223 Red Bud Av — Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Hemorrhage

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c): 331X

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____

Death occurred at 2081 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Paul J. Simon Deputy Coroner

22b. ADDRESS: 1300 Clark

22c. DATE SIGNED: 1/30/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: Feb. 1, 1960

23c. NAME OF CEMETERY OR CREMATORY: New Bethlehem Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis County, Missouri

24. FUNERAL DIRECTOR — ADDRESS: Math Hermann & Son, Inc., 2161 E. Fair Av

25. DATE RECD. BY LOCAL REG.: JAN 30 1960

26. REGISTRAR'S SIGNATURE: Noel Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT — MEDICAL CERTIFICATION — BY AFFIDAVIT OF

7171

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 Clement McNeany

Licensed Embalmer No. 3232

P. O. Address St. Louis

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