

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021513

XC-296 791

SL 7410

STATE FILE NUMBER

FILED VS MAY 23 1960

Primary Registration District No. _____ Registrar's **2-3654**

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| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. Louis | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO. | | Length of stay in 1b 20 days | | c. CITY OR TOWN WEBSTER GROVES | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 621 ROBINSON AVE. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HENRY Middle A. E. Last SEIDER | | | 4. DATE OF DEATH Month MARCH Day 30 Year 1960 | | | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 4/3/93 | 9. AGE (last birthday) 68 | 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) MAINTENANCE WORK | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) DENMARK | 12. CITIZEN OF WHAT COUNTRY USA | | |
| 13a. FATHER'S NAME JOHAN A. SEIDER | | | 13b. MOTHER'S MAIDEN NAME CHRIS M. THOMPSON | | | 14. NAME OF HUSBAND OR WIFE RIGMORE SEIDER | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES | | 16. SOCIAL SECURITY NO. WW-1 490-01-9963 | | 17. INFORMANT Webster Groves, Mo. Rigmore Seider, 621 Robinson Ave., | | | | |
| 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) CARCINOMATOSIS | | | | | | 6 WEEKS | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CANCER OF THYROID | | | | | | 6 WEEKS | | |
| DUE TO (c) CARCINOMA OF LEFT LUNG - 163x - | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) POST OPERATIVE ABDOMINO PERINEAL RESECTION FOR CARCINOMA OF | | | | | | 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 | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of toxin in PART I or PART II of item 18.) RETINUM | | | | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | | STATE | | |
| 21. PA attended the deceased from 3/10/60 to 3/30/60 and last saw him alive on 3/30/60 Death occurred at 4:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Donald R. Seider, M.D. | | | | 22b. ADDRESS VAH, ST. LOUIS, MO. | | 22c. DATE SIGNED 3/30/60 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE 4-2-60 | 23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery | | 23d. LOCATION (City, town, or county) Kirkwood, Mo. | | (State) | | |
| 24. FUNERAL DIRECTOR Parker-Aldrich, Webster Groves | | | 25. DATE RECD. BY LOCAL REG. MAR 31 1960 | | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | | | |

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

Lucie Welch

Licensed Embalmer No. 4395

P. O. Address Whiter St

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.