

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

6562 -61-027343  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1003**

FILED JUL 26 1961

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>Life</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>Jewish Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5588 Waterman Ave</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thelma Lee Siegel</b>				4. DATE OF DEATH Month Day Year <b>July 14, 1961</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>6/5/1907</b>	9. AGE (last birthday) <b>54</b>	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) <b>Statistition</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Club of Mo</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Hugh Siegel</b>			13b. MOTHER'S MAIDEN NAME <b>Ida Mae Kieley</b>		14. NAME OF HUSBAND OR WIFE <b>None</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>				17. INFORMANT Address <b>Barbara Schratwieser 6301 Asher St New Orleans, La</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>Carcinomatous</b> DUE TO (b) <b>Carcinoma of Heart.</b> DUE TO (c) <b>170+</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)						INTERVAL BETWEEN ONSET AND DEATH <b>18 mos.</b> <b>18 mos.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>None.</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour s.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. I attended the deceased from <b>1954</b> to <b>7/14/61</b> and last saw her <b>live</b> on <b>7/13/61</b> Death occurred at <b>9:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Laura M. Volter MD</b> (Degree or title)				22b. ADDRESS <b>4409 W. Olive</b>		22c. DATE SIGNED <b>7/14/61</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>July 14, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>		23d. LOCATION (City, town, or county) <b>St. Louis Co, Missouri</b>		(State)		
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons 6175 Delmar Blvd</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>JUL 14 1961</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>		

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

Dr. L.M. Kotner

4409 West Pine Blvd.

Je. 1-8593

1 to 4:30 P.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me or by NO EMBALMING Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_ Signature of Student Embalmer

Signed Jos McCulloch Licensed Embalmer No. 27000

P. O. Address 6150 2nd

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.