

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

3860

-62-017259

STATE FILE NUMBER

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

FILED APR 25 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in 1b	c. CITY OR TOWN <u>O'Fallon</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>413 St. Patrick Dr.</u>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>MILDRED</u> Middle <u>K.</u> Last <u>SIADK</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>11</u> Year <u>1962</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19/12</u>	9. AGE (last birthday) <u>49</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Cairo Ill.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13a. FATHER'S NAME <u>James W. Maynard</u>		13b. MOTHER'S MAIDEN NAME <u>Lilly Holter</u>	
14. NAME OF HUSBAND OR WIFE <u>Peter Siadek</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Peter Siadek 413 St. Patrick &</u>			

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) <u>PULMONARY INSUFFICIENCY</u>		<u>1 WEEK</u>
DUE TO (b) <u>COR PULMONALE</u>		<u>SEVERAL YRS.</u>
DUE TO (c) <u>CHRONIC BRONCHITIS AND ASTHMA</u> <u>502.1</u>		<u>12 YEARS</u>

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 <input type="checkbox"/> NO <input checked="" 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 _____ 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. I attended the deceased from APRIL 6, 1962 to APRIL 11, 1962 and last saw her/him alive on APRIL 11, 1962
 Death occurred at 1:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>C. D. Vermillion, M.D.</u>	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>4/11/62</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4/14/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>	23d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u>
---	-----------------------------	---	---

24. FUNERAL DIRECTOR <u>Robert D. Kinealy 2228 St. Louis Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>APR 12 1962</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>
--	--	--

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

1

3

4 1

5 1

6

7 1

8 2

9

10

11

12 52-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT BY AFFIDAVIT OF

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert J. Gann Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22 Mo.

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.