

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space. **3831**

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **5801** Page **2**)

File No.....
Registered No. **2382**
St. Ward)

2. FULL NAME

Frieda B. Sievers

(a) Residence. No. St. **6** Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widow**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Caron Sievers**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Aug 20, 1864**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
62 **6** **16**

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **At Home**
(b) General nature of industry, business, or establishment in which employed (or employer) **1930 B**
(c) Name of employer

BIRTHPLACE (CITY OR TOWN) **Riga**
(STATE OR COUNTRY) **Russia**

10. NAME OF FATHER **Jones Kaplan**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Russia**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Bertha Brill**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Russia**
(STATE OR COUNTRY)

14. INFORMANT **Samuel S. Sievers**
(Address) **Hullerton Bldg**

15. FILED **10 1937** **Mar 6 Starckoff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 8** 19 **27**

17. I HEREBY CERTIFY, That I attended deceased from **Nov** 19**26**, to **March 8** 19**27** that I last saw **her** alive on **March 6** 19**27**, and that death occurred, on the date stated above, at **11** **PM**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis

CONTRIBUTORY (SECONDARY) **Acute Pleurisy with Effusion**
(duration) **2** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **We know**
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **X-ray**
(Signed) **H. D. Spector**, M. D.
3/9 19**27** (Address) **837 New Club Bldg**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Beth Ham Hag** DATE OF BURIAL **3/10 1927**

20. UNDERTAKER **H B Berger** ADDRESS **1715 McPherson**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

