

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

Do not use this space.

JUN 12 1937

**791
1003**

18578

File No. _____
Registered No. **5154**
St. _____ Ward _____

1. PLACE OF DEATH

County _____

Registration District No. _____

Township _____

Primary Registration District No. _____

City **St. Louis**

(No. **City Hospital No. 1**)

C 815

2. FULL NAME

Wm. Sieckmann

(a) Residence, No. _____

3801 North 22nd st., 20

Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX
male

4. COLOR OR RACE
white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **5/22/37** 19

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

Carrie Sieckmann

22. I HEREBY CERTIFY, That I attended deceased from
4/17/37, 19, to **5/22/37**, 19.

I last saw him alive on **5/22/37**, 19. Death is said

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jan. 16, 1870**

7. AGE
67 YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

to have occurred on the date stated above, at **8:35a**

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **nil**

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **House Painter**

10. Date deceased last worked at this occupation (month and year) _____ **11. Total time (years) spent in this occupation** _____

Cerebral hemorrhage
Bronchopneumonia

Date of onset

Other contributory causes of importance:

Generalized arteriosclerosis

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**

13. NAME **Henry Sieckmann**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

15. MAIDEN NAME **Ernestine (dont know)**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? **yes**

17. INFORMANT (ADDRESS) **Hosp. Info. M.H. Kent**

18. BURIAL, CREMATION, OR REMOVAL PLACE **New Bethlehem** DATE **May 24, 1937**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

19. UNDERTAKER (ADDRESS) **Cullinane Bros. 1710 N. Grand Blvd.**

24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____

20. FILER (ADDRESS) **MAY 24 1937 J. Bredeek Registrar.**

(Signed) **Charles M. Jessier**, M. D.
(Address) **City Hospital No. 1**

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.

