

S. No. 2
-1-4-41
5-17-39
X 26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36843

State File No. _____

Registrar's No. **9073**

DEC 22 1941
Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Luke's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Illinois** (b) County **Cook**
(c) City or town **Chicago**
(If outside city or town limits, write "RURAL")
(d) Street No. **5421 Wayne Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (c) PRINT FULL NAME **Annie O. Siekman**
3. (b) If veteran, name war **No.**
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **November** day **15**
year **1941** hour **4** minute **37 A.M.**
21. I hereby certify that I attended the deceased from **November 3**
1941 to **November 15** 1941;
that I last saw her alive on **November 15** 1941;
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Herbert C.**
6. (c) Age of husband or wife if alive **36** years
7. Birth date of deceased **Jan. 9 1904**
(Month) (Day) (Year)

Immediate cause of death
Ptd. Pneumonia - Rx + So not specified
Paralysis Cytaria
Post Encephalitis
Due to _____
Due to **Acute Pulmonary Edema**
Other conditions (include pregnancy within 3 months of death)
Major findings: **Paralysis Cytaria**
Of operations _____
Of autopsy _____

8. AGE: Years Months Days If less than one day
37 **10** **6** hr. min.

9. Birthplace **Pipestone Minn.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Frank Johnson**
13. Birthplace **Sweden**
(City, town, or county) (State or foreign country)
14. Maiden name **Carrie Beck**
15. Birthplace **Sweden**
(City, town, or county) (State or foreign country)

16. (a) Informant **Herbert C. Siekman**
(b) Address **Chicago, Ill.**

17. (a) **Removal** (b) Date thereof **11/6-41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Chicago, Ill.**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Ave.**

19. (a) **NOV 15 1941** (b) **J. H. Budeck**
(Date received local registrar) (Registrar's signature)

PHYSICIAN
Underline the cause to which death should be charged statistically.
37
27

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

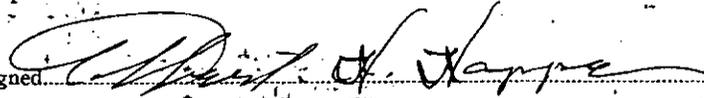
23. Signature **J. M. Klumac** (M. D. or other)
Address **4952 Maryland** Date signed **11/15/41**
(Specify type of place) (Means of injury)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
..... Registered Apprentice No.....
working under my personal supervision.

Signed



Licensed Embalmer No. 1861

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.