

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12784

State File No.

LED APR 19 1948 818

Registration District No.

Primary Registration District No. 1003

Registrar's No. 3092

1. PLACE OF DEATH:

(a) County St. Louis
(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. John 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 _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Oron Essex Siefke.

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Laura Siefke 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Aug. 23, 1895.
(Month) (Day) (Year)

8. AGE: Years 47 Months 7 Days 6 If less than one day hr. min.

9. Birthplace E. St. Louis, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Sheet Metal Worker

11. Industry or business Own Business

12. Name James Siefke

13. Birthplace Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Ida Essex

15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Laura Siefke
(b) Address 5948 Lotus Ave.,

17. (a) Burial (b) Date thereof April 2/43.
(Burial, cremation, or removal) (City or town) (County) (State) (Year)

(c) Place: burial or cremation Mt. Hope Cem.,

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiamont Ave.,

19. (a) 1/1/48 (b) J. F. Budick
(Date received legal certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000
(c) City or town St. Louis. (If outside city or town limits, write "RURAL")
(d) Street No. 5948 Lotus Ave., (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 29
year 1943 hour 10.15 minute P.M. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Spinal Anesthesia
Hemorrhoidectomy
Due to Following Operation for
Hemorrhoids at St. Johns Hosp
Due to on March 29, 1943
exact time unknown
Other conditions _____
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: 195
Of operations 99
Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 000
(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?

While at work? _____ (Specify type of place) (e) Means of injury 0

23. Signature James J. Fitzhugh (M. D. or other)
Address 11300 Clark Date signed _____

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

MOTHER FATHER

CITY CORONER

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. 3225.....
P.O. Address 1125 Hodiarnont Ave.,

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.