

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44607**
5672

FILED JAN 17 1953

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (In this place) Life		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		d. STREET ADDRESS (If rural, give location) 3827 Park	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital				3. NAME OF DECEASED (Type or Print) a. (First) FREDERICK b. (Middle) A. c. (Last) SIEVERS			
5. SEX Ma		6. COLOR OR RACE Wh		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 5-28-1899	
9. AGE (In years last birthday) 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sta. Engineer		10b. KIND OF BUSINESS OR INDUSTRY Packing Co.		11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME August F. Sievers		13b. MOTHER'S MAIDEN NAME Elizabeth Weber		14. NAME OF HUSBAND OR WIFE Mrs. Lillian Sievers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 510-05-5679		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Lillian Sievers, 3827 Park KC Mo			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis Acute Diffuse ANTECEDENT CAUSES Paracoccidial Colic DUE TO (b) _____ DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 153X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Aboul				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE Russell W. Kerr MD (Degree or title)				23b. ADDRESS St. Joseph Hosp		23c. DATE SIGNED 12-23-52	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 12-26-52		24c. NAME OF CEMETERY OR CREMATORY Floral Hills		24d. LOCATION (City, town, or county) (State) Kansas City Mo.	
DATE REC'D BY LOCAL REG. 12-26-52		REGISTRAR'S SIGNATURE Geraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. W. Wagner, K C Mo.			

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Alvin R. Hauschild

Licensed Embalmer No. 4159

P. O. Address B. C. 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 this body is not embalmed, fact should be so stated above.