Health, Welfare Public Service

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FILED NOV 8 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

55514
STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 283

1. PLACE OF DEATH
a. COUNTY: CALLAWAY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: FULTON, MISSOURI — Inside Limits: Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: STATE HOSPITAL NO. 1 — Length of stay in 1b: 21 YRS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: MARIES
c. CITY OR TOWN: VIENNA 06301 — Inside Limits: Yes ☐ No X
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: MARTHA Middle: Last: SIEBERT
4. DATE OF DEATH Month: OCTOBER Day: 22 Year: 1956
5. SEX: FEMALE 1
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐ 2
8. DATE OF BIRTH: 1904
9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (City and state or country): MISSOURI 8
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): UNKNOWN (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT Address: STATE HOSPITAL NO.1, FULTON, MISSOURI

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 491 X
19. WAS AUTOPSY PERFORMED? YES ☐ NO X
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. X Attended the deceased from SEPT. 14, 1935 to OCT. 22, 1956 and last saw her/him alive on OCT. 22, 1956
Death occurred at 11:45 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: H. G. Freund, M.D. (Degree or title) 0
22b. ADDRESS: STATE HOSPITAL #1, FULTON, MO.
22c. DATE SIGNED: 10-23-56

23a. BURIAL, CREMATION, REMOVAL (Specify): Anatomical Board
23b. DATE: Oct. 29, 1956
23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
23d. LOCATION (City, town, or county) (State): Columbia Mo.

24. FUNERAL DIRECTOR: Robert D. Johnston ADDRESS: Columbia, Mo.
25. DATE RECD. BY LOCAL REG.: Oct. 29-1956
26. REGISTRAR'S SIGNATURE: Maretta Lawrence

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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