

FILED JUN 26 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

57 022884  
State File No.

5791

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) <b>53 yrs</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) <b>16 Hospital OR Institution Mo. Baptist Hospital</b>				STREET ADDRESS (If rural, give location) <b>247 5251 Davison Avenue</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>John</b>		b. (Middle) <b>M.</b>		c. (Last) <b>Seibert</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>June 20 1957</b>	
5. SEX <input checked="" type="checkbox"/> Male		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>June 2, 1885</b>	
9. AGE (In years last birthday) <b>72</b>		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) <b>Retired-Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>United Shoe Mach.</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Camp Springs, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Mike Seibert</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Della Seibert</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Della Seibert, 5251 Davison Avenue 9</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma mediastinitis</b>					
		ANTECEDENT CAUSES DUE TO (b) <b>Carcinoma pericardium</b>					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS <b>150x</b>					
		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <b>6-11-57</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma pericardium</b>				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 <b>6-8-57</b> , 19____, to <b>6-19-57</b> , 19____, that I last saw the deceased alive on <b>6-19-57</b> , 19____, and that death occurred at <b>2:30 Am.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>James R. Meador m.d.</b> (Degree or title)				23b. ADDRESS <b>U.S. Central</b>		23c. DATE SIGNED <b>6-20-57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>June 22, 1957</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>JUN 21 1957</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith m.d.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>CALVIN F. FEUTZ FUNERAL HOME, 4828 Natural Bridge Boulevard 15</b>			

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

FILE IN CITY

**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.....  
Signature of Student Embalmer

Signed *John A. Mlesnar*.....

Licensed Embalmer No. *4118*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.