

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

57 0 2 2 8 8 6  
State File No. ....

FILED JUN 20 1957

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		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 township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Little Flower Con. Home</b>				e. STREET ADDRESS (If rural, give location) <b>3732 A. Ohio Ave</b>					
3. NAME OF DECEASED (Type or Print) <b>MICHAEL</b>		a. (First)		b. (Middle)		c. (Last) <b>SEVERIEN</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>6-10-1957</b>			
8. DATE OF BIRTH <b>12-6-1880</b>		9. AGE (In years last birthday) <b>76</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 Machinist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Century Electric Co</b>		11. BIRTHPLACE (City and State or Foreign Country) / <b>Pennsylvania</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13a. FATHER'S NAME <b>George Severien</b>		13b. MOTHER'S MAIDEN NAME <b>Mary????</b>			
14. NAME OF HUSBAND OR WIFE				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>494-10-0904A</b>			
17. INFORMANT'S SIGNATURE OR NAME <b>Oscar B. Schaefer</b>				ADDRESS <b>Public Administrator</b>					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.  <b>3-14-57</b>				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Stomach.</b> <b>(Carcinoma of stomach)</b>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>151X</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
19a. DATE OF OPERATION <b>3/14/57</b>		19b. MAJOR FINDINGS OF OPERATION <b>Barnes Hosp. - Inoperable cancer of stomach</b> <b>BARNES Hospital - Inoperable cancer of stomach.</b>				19c. AUTOPSY? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		20b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21a. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>6-9-57</b>		21b. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21c. HOW DID INJURY OCCUR? <b>2-12-57 6-10-57</b>					
22. I hereby certify that I attended the deceased from <b>Feb 1, 1957</b> , to <b>June 10, 1957</b> , that I last saw the deceased alive on <b>June 9, 1957</b> , and that death occurred at <b>3 P.M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>Rose B. Sommer</b>				23b. ADDRESS <b>100 N. Euclid</b>		23c. DATE SIGNED <b>6/12/57</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>6-14-1957</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Peter and Paul's Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>7030 Gravois Ave. Mo</b>			
DATE REC'D BY LOCAL REG. <b>JUN 13 57</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Ziegenfuss</b>		ADDRESS <b>6409 Gravois Ave</b>			

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

(Licensed Embalmer's Statement on Reverse Side)

COUNTY OF ST. LOUIS  
 STATE OF MISSOURI  
 DEPARTMENT OF HEALTH  
 DIVISION OF PUBLIC HEALTH  
 ST. LOUIS, MISSOURI  
 12-3-1980  
 BY 3777  
 PUBLIC HEALTH DEPARTMENT  
 ST. LOUIS, MISSOURI

**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..... *James M. Seymour* .....

Licensed Embalmer No. 434

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.