

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001684

STATE FILE NUMBER

Registration District No. 150 Primary Registration District No. 5574 Registrar's No. 41

1. PLACE OF DEATH  
a. COUNTY Jackson  
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN VanBuren Twp. Inside Limits Yes  No   
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 1 1/2 Mi. S.E. Lone Jack Length of stay in lb 9 Years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Missouri b. COUNTY Jackson  
c. CITY OR TOWN Lone Jack Inside Limits Yes  No   
d. STREET ADDRESS (If outside, give location) 1 1/2 Mi. S.E. of Town Reside on Farm Yes  No

3. NAME OF DECEASED (Type or print) First Winfred Middle A Last Sieh  
4. DATE OF DEATH Month Feb. Day 7 Year 1959

5. SEX Male 6. COLOR OR RACE White 7. MARRIED  NEVER MARRIED  WIDOWED  DIVORCED   
8. DATE OF BIRTH March 15 1898 9. AGE (In years at birthday) 60 10. FUNDER 1 YEAR Months 0 Days 0 11. IF UNDER 24 HRS. Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY Farm 11. BIRTHPLACE (City and state or country) Sioux City Iowa. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME George H. Sieh 13b. MOTHER'S MAIDEN NAME Minnie Peaker 14. NAME OF HUSBAND OR WIFE Florence L. Sieh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 510-05-7019 17. INFORMANT Florence L. Sieh Address Lone Jack Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Chronic myocarditis INTERVAL BETWEEN ONSET AND DEATH 28 min.  
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) \_\_\_\_\_

19. WAS AUTOPSY PERFORMED? YES  NO

20a. ACCIDENT  SUICIDE  HOMICIDE  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 4222

20c. TIME OF INJURY Hour \_\_\_\_\_ a.m. \_\_\_\_\_ p.m. \_\_\_\_\_

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. I attended the deceased from Friday Feb. 6th to Feb 7 1959 and last saw him alive on Feb 7 1959. Death occurred at 7:10 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John C. Adams D.D. 22b. ADDRESS Lone Jack, Mo 22c. DATE SIGNED 2-7-59

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE 2/10/1959 23c. NAME OF CEMETERY OR CREMATORY Graceland Cem. 23d. LOCATION (City, town, or county) (State) Sioux City Iowa.

24. FUNERAL DIRECTOR Langsford Funeral Home Lee's Summit Mo. ADDRESS \_\_\_\_\_ 25. DATE RECD. BY LOCAL REG. 2/8/59 26. REGISTRAR'S SIGNATURE W.B. Langsford

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Health, Welfare, Public Service

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FILED FEB 13 1959

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MAR 1 1959

KS JUN 1 1960

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 *M. B. Langford* .....

Licensed Embalmer No. *3833* .....

P. O. Address *Jess. Summit 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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