

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-047194

FILED VS JAN 5 1961

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 261

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Saint Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Charles</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Saint Charles</u>		Length of stay in 1b <u>3 days</u>		c. CITY OR TOWN <u>O'Fallon</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Saint Joseph's Hospital</u>				d. STREET ADDRESS (If outside, give location) <u>RFD # 2</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>A.</u> Last <u>Siesennoy</u>				4. DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-1883</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (City and state or country) <u>Saint Peters, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Conrad Kuester</u>		13b. MOTHER'S MAIDEN NAME <u>Theresa Schulte</u>		14. NAME OF HUSBAND OR WIFE <u>Edward F Siesennoy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs Helen Scheller RFD # 2 O'Fallon Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pyelonephritis & Pyelonephrosia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
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) <u>Arteriosclerotic & Hypertensive Cardiovascular</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (state nature of injury in PART I or PART II of item 18.) <u>None</u>					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		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 <u>December 18, 1960</u> to <u>December 21, 1960</u> and last saw her alive on <u>December 21-1960</u> Death occurred at <u>3:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Dorothy Randall, M.D.</u>				22b. ADDRESS <u>220 S. 6th St. St. Charles, Mo.</u>		22c. DATE SIGNED <u>Dec. 23 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12-23-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Assumption Cemetery</u>		23d. LOCATION (City, town, or county) <u>O'Fallon Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>O'Fallon Mortuary Inc. 206 E. Elm Charles J Callahan</u>				25. DATE REGD. BY LOCAL REG. <u>12/23/60</u>		26. REGISTRAR'S SIGNATURE <u>Aracella Wilson</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles J. Callahan

Licensed Embalmer No. 5128

P. O. Address O'Fallon Y

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.