

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009396

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1351**

STATE FILE NUMBER

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b 25 Min.	c. CITY OR TOWN St. Louis, Mo. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Children's Hosp		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 10424 Baron Drive Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last John Walter Siadek			4. DATE OF DEATH Month Day Year 2-6-63
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-31-55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (last birthday) 7
13a. FATHER'S NAME James Andrew Siadek		13b. MOTHER'S MAIDEN NAME Edith Boatwright	11. BIRTHPLACE (City and state or country) Norfolk, Virginia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		12. CITIZEN OF WHAT COUNTRY U.S.A.	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchopneumonia - dehydration 1 day		14. NAME OF HUSBAND OR WIFE Single	
DUE TO (b) Microcephaly		16. SOCIAL SECURITY NO.	
DUE TO (c) Cerebral spasticity 7534		17. INFORMANT Alice Trowbridge, 500 S. Kingshighway	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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 6 Feb 63 to 6 Feb 63 and last saw him alive on 6 Feb 63 Death occurred at 11:10 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Sheldon Kramer, M.D.		22b. ADDRESS 890 West St. Anthony La Florissant, Missouri	22c. DATE SIGNED 6 Feb 63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-9-63	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. FEB 7 1963	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

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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 embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Frederic L. Kemper

Licensed Embalmer No. 4052

P. O. Address 4911 Washington

St. Louis, 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.