

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-030513

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7170**

FILED JUL 19 1963

VS 300
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN St. Ann	
Length of stay in 1b 5 Weeks		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If outside, give location) 10246 St. Anthony La.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ida A. Sieland			4. DATE OF DEATH Month July Day 9 Year 1963
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/1/1890
9. AGE (last birthday) 72		IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0	IF UNDER 24 HR Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Frank D. Strong	
13b. MOTHER'S MAIDEN NAME Anna Thompson		14. NAME OF HUSBAND OR WIFE Henry H. Sieland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Henry H. Sieland		Address 10246 St. Anthony La.	
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic heart disease - Diabetes Mellitus - CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) Right Hemiplegia DUE TO (c) 420.0			INTERVAL BETWEEN ONSET AND DEATH
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 checked="" 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 9:55 a.m. p.m. Month, Day, Year	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 June 8, 1963 to July 9, 1963 and last saw her 7-8-63 alive on 7-8-63 . Death occurred at Deaconess Hospital 9:55 p.m. of the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. E. Williamson M.D.		22b. ADDRESS 6536 Clayton Road	
22c. DATE SIGNED 7-10-63		22d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b. DATE 7/12/1963	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24. FUNERAL DIRECTOR Collier Mortuary, St. Ann, Mo.		25. DATE RECD. BY LOCAL REG. JUL 10 1963	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

58

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

Sheldon Collier

Licensed Embalmer No.

3382

P. O. Address

J. T. Armstrong

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.