No. 2
8-43
5-17-39
I X37825

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 6 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33590

Registration District No. 80 — Primary Registration District No. 5307 — Registrar's No. 8

1. PLACE OF DEATH:
(a) County Cole County Moreau T.S.
(b) City or town California Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cole
(c) City or town ____ (If outside city or town limits, write "RURAL")
(d) Street No. ____ (If rural, give location) 0
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Clyde Arthur Siebert
3. (b) If veteran, name war --
3. (c) Social Security No. ---

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased March (Month) 15th (Day), 1899 (Year)

8. AGE: Years 46 | Months 7 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace California Rural (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farmer
11. Industry or business ____

MOTHER FATHER
12. Name C. C. Siebert
13. Birthplace New York. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Wilhelmina C. Althoff
15. Birthplace California, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Oscar Siebert
(b) Address California, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/45 (Month) (Day) (Year)
(c) Place: burial or cremation Salem Cem.
18. (a) Signature of funeral director H. D. Schubert
(b) Address Russellville, Mo.
19. (a) Oct. 25 (Date received local registrar) (b) Mrs. Minnie Hittenmeyer (Registrar's signature)

1434

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 15th
year 1945 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Drowning	
Due to Drowning	
Due to Drowning	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Suicide
(b) Date of occurrence October 15 1945
(c) Where did injury occur? Moreau River (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? On Farm (Specify type of place)
While at work? (e) Means of injury Drowning

23. Signature Foster J. Keeley Acting Coroner (M. D. or other)
Address City Hall Jeff City Mo 5 Date signed 10/29/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 11-5-45

JAN 28 1946

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....., Registered Apprentice No....., working under my personal supervision.

Signed W. W. Schubert

Licensed Embalmer No. 2820

P. O. Address Russellville, Ky

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

S. No. 2B
0M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11 or

Registration District No. 80 Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:
(a) County Cole
(b) City or town Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Cole
(c) City or town California Rural (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Clyde A. Siebert
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Mar (Month) 15 (Day) 1894 (Year)

8. AGE: Years 46 Months 7 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) Mrs. Minnie Kittenmayer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar 15 day
year 1945 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

33590