

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

3037

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City St. Louis

City St. Hospital

File No.....

Registered No. 628

St.....

Ward.....

2. FULL NAME

Morris Steinback

(a) Residence, No. 5073 Enright Ave, St. 12 Ward.

Length of residence in city or town where death occurred

yrs.

mos.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Lillie Steinback

6. DATE OF BIRTH (MONTH, DAY AND YEAR) not known 1880

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

abt. 47

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Tilling Station

(b) General nature of industry, business, or establishment in which employed (or employer)

Prop. + garage

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Russia

10. NAME OF FATHER

Frank Steinback

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Russia

12. MAIDEN NAME OF MOTHER

Naomi

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Russia

PARENTS

14

INFORMANT

(Address)

Louis Steinback
5073 Enright Ave

15

FILED

19 1927

Max G. Starkoff

REGISTERED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-18-27 19

17.

I HEREBY CERTIFY, That I attended deceased from

....., 19....., to

....., 19.....

that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gun shot wound of abdomen

173 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

Homicide

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Wm. Dewey M.D.
119.27 (Address) Dep. Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Bnai Amoona

1/20 1927

20. UNDERTAKER

ADDRESS

H. B. Berger

415 McPherson

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

