

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

Do not use this space.

21978

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis Mo.*

Registration District No. **791**
1003
Primary Registration District No.

File No.
Registered No. **6142**
St. Ward)

2. FULL NAME

Emma Steinberg
(a) Residence No. *1550 North 19th* W. Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 31 1865*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<i>63</i>	<i>2</i>	<i>5</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *House Wife*
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *St. Louis Mo.*
(STATE OR COUNTRY)

10. NAME OF FATHER *Unknown*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Unknown*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Unknown*
(STATE OR COUNTRY)

14. INFORMANT *Edward St. Steinberg*
(Address) *4116 Cleveland Ave.*

15. FILED *LN -8 1928* *May C. Starnoff* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 6 1928*

17. I HEREBY CERTIFY, That I attended deceased from *May 29*, 1928, to *June 6*, 1928 that I last saw *h. h. h.* alive on *June 6*, 1928, and that death occurred, on the date stated above, at *10:50 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

87H
97 (duration)..... yrs. mos. *9* ds.

CONTRIBUTORY *Arterio-sclerosis* (SECONDARY) (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? *7401*
IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....
WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?
6/6 (Signed) *Edwin P. Meier*, M. D.
6/6, 1928 (Address) *6600 Delmar Blvd.*

*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 *Sunset Burial Ph.* DATE OF BURIAL *6-8-1928*

20. UNDERTAKER *Ziegenfuss Bros. 2623 Cherokee St.* ADDRESS

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.

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

