

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

Do not use this space.

41409

1. PLACE OF DEATH

County.....

Registration District No. **7911**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No.

Registered No. **12092**

St. Ward)

2. FULL NAME

(a) Residence. No. **912 N. Brady St. 25** Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred **8** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

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

male white divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **1-30-1878**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	52	11	21	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Michigan**

10. NAME OF FATHER **Michael Steining**

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

12. MAIDEN NAME OF MOTHER **unknown**

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

14.

INFORMANT **Ed. ...**
 (Address) **City Hospital**

15.

DEC 27 1930
 FILED **19**

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Dec 20 1930**

17. I HEREBY CERTIFY that I attended deceased from **Dec 19 30** to **Dec 20 30** that I last saw him alive on **Dec 20 1930**, and that death occurred, on the date stated above, at **2:50 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
109

CONTRIBUTORY (SECONDARY) **1010W**

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....

WAS THERE AN AUTOPSY? **NO**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **Joseph T. Fisher** M. D.
 (Address) **City Hospital**

*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

Mo. Crematory

12-29 1930

20. UNDERTAKER

ADDRESS **2621
Chester**

Zugelder

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.

Hannover