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.

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

Do not use this space.

41963

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 11074

City St Louis Mo (No. on Route City Hospital #1 St. ..... Ward)

2. FULL NAME Henry Steinkamp

(a) Residence, No. 2560 N. Broadway St., 26 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Dont know

7. AGE: About 55 YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. General Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 237

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany 11

FATHER

13. NAME: Henry Steinkamp

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

MOTHER

15. MAIDEN NAME: Not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

17. INFORMANT (ADDRESS): Geo. Steinkamp 4242 Red Bud ave.

18. BURIAL, CREMATION, OR REMOVAL
PLACE St Johns North DATE Dec 16 1932

19. UNDERTAKER (ADDRESS): Hy Leidner Und Co 1418 N. Market St.

20. FILED DEC 14 1932 19 Max C Stanley Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 12 1932

22. No Physician in attendance HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 12 15 m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Apoplexy 82A	

Other contributory causes of importance: 82A

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury No Injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) [illegible], M.D.

(Address) Deputy Coroner

12/14/32