

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.

DEPT. MAR 4 13 1939
247

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

4483
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**

(b) Township Primary Registration District No. **1003**

(c) City **St. Louis.** (d) Street No. **City Hospital.** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Robert F. Steinbrecher.**

(a) Residence, No. **6549 Marmaduke Av.** St. **3** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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 **Anna Steinbrecher.**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Feb. 16, 1867.**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 11 18

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Shirt Cutter.**

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

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) **Illinois.**

FATHER

13. NAME **Charles Steinbrecher.**

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

MOTHER

15. MAIDEN NAME **Unknown.**

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

17. INFORMANT **Anna Steinbrecher.**
(ADDRESS) **6549 Marmaduke Av.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **St. Peters Cemetery** **Feb. 7th, 1939.**

19. FUNERAL DIRECTOR (NAME) **Ziegenhain Bros.**
(ADDRESS) **2623 Cherokee St.**

20. FILED **FEB 6 1939** **J. D. Bredes**
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb. 4th 1939**

22. I HEREBY CERTIFY, That I attended deceased from **1-27**, 19**39**, to **2-3**, 19**39**

I last saw h. im. alive on **Feb. 3th 1939.**, 19... Death is said to have occurred on the date stated above, at **5.35** m. P. M.

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

Chronic Myocarditis Date of onset **?**

Chronic Nephritis **?**

Other contributory causes of importance

Name of operation **None** Date of.....

What test confirmed diagnosis? **Urinal** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? **No** 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.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **No**
If so, specify.....
(Signed) **Bernard Plack**, M. D.
(Address) **3527 Osage St. St. Louis, Mo**

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 _____

V E Morris

Licensed Embalmer No. _____

3360

P. O. Address _____

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, above space should be left blank.