

FILED APR 15 1940

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH

(a) County _____
(b) City or town _____
(c) Name of hospital or institution: Route City Hospital
(d) Length of stay: In hospital or institution 3
In this community _____
years, months or days _____

3. (a) PRINT FULL NAME Henry L. STEFFEN

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years 69 Months _____ Days _____ If less than one day _____ min.

9. Birthplace MO
(City, town, or county) (State or foreign country)

10. Usual occupation Labourer

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown
13. Birthplace "
14. Maiden name "
15. Birthplace "

16. (a) Informant Bess Meyer - (D.)

(b) Address 3932 Gearhart

17. (a) _____ (b) Date thereof 2-11-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director W. Reuter
(b) Address 3500 Rubin

19. (a) MAR 4 1940 (b) _____
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 1
(c) City or town St. Louis 11
(d) Street No. 3275 Montgomery
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 28
year 1940 hour 3 minute 25 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Stenosis

Due to with concentric Hypertrophy

Due to Chronic Arteriosclerotic Hypertension with

Other conditions: systemic Degeneration

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place)
(e) Means of injury 5

23. Signature Joseph M. Quinn
Address Deputy Registrar Date signed _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

99

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 _____

Licensed Embalmer No. _____

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.