

Registration District No. **642**

Primary Registration District No. **5851**

Registrar's No. **7**

1. PLACE OF DEATH:

(a) County **Orange West Mo.**  
 (b) City or town **Orangeville Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
years, months or days **255**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Orange**  
 (c) City or town **Orangeville Mo.**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Anna Catherine Steiman**

3. (b) If veteran, name war **none** 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife **Bernard Steiman** 6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **Aug 21 1877**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>67</b>	<b>—</b>	<b>14</b>	hr. _____ min. _____

9. Birthplace **Kellytown Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_

12. Name **Bernard Hicke**

13. Birthplace **Germany**  
(City, town, or county) (State or foreign country)

14. Maiden name **Margaret Schaffer**

15. Birthplace **Kellytown Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Ben Steiman**

(b) Address **Orangeville Mo.**

17. (a) **Burial** (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Burial**

18. (a) Signature of funeral director **H. H. Stroppe**

(b) Address **meta**

19. (a) **9/5/40** (b) **Mary W. Blaylock**  
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept. 4** day \_\_\_\_\_  
 year **1940** hour **16** minute **30** M.

21. I hereby certify that I attended the deceased from **Aug. 1** 19**40** to **Sept. 4** 19**40**;  
 that I last saw her alive on **in Sept. 4** 19**40**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Rectum** Duration \_\_\_\_\_

Due to **do not present.**

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: **Carcinoma of bowels - caecum, sigmoid**  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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?  
**573** \_\_\_\_\_  
(Specify type of place) While at work? (e) Means of injury \_\_\_\_\_

23. Signature **H. S. Jacobson** (M. D. or other) \_\_\_\_\_

Address **Orangeville Mo.** Date signed **9/5/40**

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

I X21492

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FILED SEP 25 1940

**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 H H Strop

Licensed Embalmer No. 2924

P. O. Address Meta mo

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **29271**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **642**

Primary Registration District No. **3861**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Osage**  
(b) City or town **Washburn, T.P.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Anna Catherine Steinman**  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month **Sept** day **4**  
year **1946** hour \_\_\_\_\_ minute \_\_\_\_\_ M. \_\_\_\_\_

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **m**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

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 **Carcinoma of Rectum**

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)  
8. AGE: Years **63** Months \_\_\_\_\_ Days **14** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions **Car**  
(Include pregnancy within 3 months of death)

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
10. Usual occupation \_\_\_\_\_

Major findings: **Carcinoma of lower bowels**  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)  
(c) Place: burial or cremation \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

23. Signature **H. G. Freburger** (M. D. or other) \_\_\_\_\_  
Address **Argyle, Ind.** Date signed \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**SUPPLEMENTARY**  
*Death cert. was  
between death &  
disposal of car  
date filed  
Sep 7/46.*

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

MOTHER FATHER

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

