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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 21 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32390

Registration District No. 71 Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town Wentzville Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: East Allen
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 13 yrs. 1
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St. Charles
(c) City or town Wentzville Mo. 69
(If outside city or town limits, write "RURAL")
(d) Street No. Allen Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME August Henry Steinhage.
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
6. (b) Name of husband or wife Lenora Steinhage
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct (Month) 3 (Day) 1863 (Year)

8. AGE: Years	Months	Days	If less than one day
75	11	2	hr. min.

9. Birthplace Warrenton (City, town, or county) Mo. (State or foreign country) U
10. Usual occupation Retired Hdw. dealer
11. Industry or business
FATHER 12. Name Fred Steinhage
13. Birthplace unknown (City, town, or county) Germany (State or foreign country)
MOTHER 14. Maiden name Julia Schaeg
15. Birthplace Warrenton (City, town, or county) Mo. (State or foreign country) U
16. (a) Informant Edwin Steinhage
(b) Address Eolia, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep 7 41 (Month) (Day) (Year)
(c) Place: burial or cremation Eolia, Mo.
18. (a) Signature of funeral director T. E. Pittman
(b) Address Wentzville, Mo.
19. (a) Sep 6 41 (Date received local registrar) (b) Gertrude S. Forister (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5
year 1941 hour 9:30 A.M. Standard P.M.
21. I hereby certify that I attended the deceased from Sept. 3, 1941 to Sept. 5, 1941
that I last saw him alive on Sept. 3, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Heart attack	12 hours
Due to: Cerebral Hemorrhage	
Due to: Arteriosclerosis	

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

118.3

PHYSICIAN
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?
While at work? (Specify type of place) (e) Means of injury
23. Signature Edwin R. Kuenne (Physician or other)
Address Wentzville Mo Date signed Sep 6 41

(Licensed Embalmer's Statement on Reverse Side)

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 P. E. Pitman

Licensed Embalmer No. 2711

P. O. Address Wentzville W

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—8-21-41
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32390

Registration District No. 760A

Primary Registration District No. 4455

Registrar's No.

1. PLACE OF DEATH

(a) County St Charles

(b) City or town Wentzville
(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 years, months or days)

In this community

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME August H. Steinhage

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife

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

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

8. AGE: Years | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day

year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;

that I last saw h alive on 19;

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY