

V. S. No. 2
DOM-5-42
Rev. 5-17-39
WI 2-12-41

6288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

MAR 11 1943

Registration District No. 117

Primary Registration District No. 5435

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County GASCONADE

(b) City or town RURAL BUEUF TOWNSHIP
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
NEAR SWISS MO.
(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) 35 YRS.

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County GASCONADE

(c) City or town RURAL
(If outside city or town limits, write "RURAL")

(d) Street No. NEAR SWISS MO.
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ALBERT FRANK STEINBECK

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 MARRIED

6. (b) Name of husband or wife AMANDA STEINBECK

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased JULY 2 1884
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>58</u>	<u>7</u>	<u>18</u>	_____ hr. _____ min.

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

10. Usual occupation FARMING

11. Industry or business _____

12. Name AUGUST STEINBECK

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

14. Maiden name LOUISE TAPPE

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

16. (a) Informant AMANDA STEINBECK

(b) Address SWISS MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 23 1943
(Month) (Day) (Year)

(c) Place: burial or cremation ST. JOHNS CEM. SWISS MO.

18. (a) Signature of funeral director M. F. Hattenstrater

(b) Address Quincyville Mo.

19. (a) 2-21-43 (Date received local registrar) (b) Mrs. F. B. Mauer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB. day 20
year 1943 hour 4 minute 10 P.M.

21. I hereby certify that I attended the deceased from Febr 16 1943 to Febr 20 1943
that I last saw him alive on Febr 20 1943
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexia
equating with stroke
hemiplegia

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____

Of autopsy none

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 John Engelbrecht (M. D. or other) _____
Address Stanghille, Mo. Date signed 2-24-43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 Me
....., Registered Apprentice No.
working under my personal supervision.

Signed Milford Winter
.....
Licensed Embalmer No. 3838
.....
P. O. Address Quensville 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, fact should be so stated above.