

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 21 1943 318

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 8209

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 Days
(Specify whether)

In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ST LOUIS

(c) City or town St. Louis, AFFTON
(If outside city or town limits, write "RURAL")

(d) Street No. 9423 Daisy Lane
(If rural, give location)

(e) Citizen of foreign country? -- (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME John Steinberg

3. (b) If veteran, name war No

3. (c) Social Security No. 498-07-8897

4. Sex 0 Male

5. Color or race White

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

6. (b) Name of husband or wife Anna Steinberg

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

7. Birth date of deceased January 28, 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<input checked="" type="checkbox"/> 72	7	15	_____ hr. _____ min.

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

10. Usual occupation Sawyer

11. Industry or business Shillington Box Company

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Edward Bechtold

(b) Address 9423 Daisy Lane, Affton, Mo

17. (a) Burial (b) Date thereof 9 16 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cem

18. (a) Signature of funeral director Robert E. Holt

(b) Address 3634 Gravois Avenue

19. (a) SEP 15 1943 (b) Robert E. Holt
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 13,
year 1943 hour 8:45 minute P. M.

21. I hereby certify that I attended the deceased from August 26, 1943 to September 13, 1943.
that I last saw him alive on September 13, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory and circulatory failure Duration 20 hrs.?

Due to Cerebrovascular accident 16 days

Due to _____

Other conditions marked generalized arteriosclerosis - ? yrs
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy Refused

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 Robert E. Holt (M. D. or other) _____
Address 1515 Lafayette Avenue, Date signed 9/14/43

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

20
17
9

N.R
096
0
0

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..... *Robert Wheeler*

Licensed Embalmer No. *2128*

P. O. Address *St Louis 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.