

7. S. No. 2
DOM-2-43
ev. 5-17-39

1 X3597

26603

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2175

FILED SEP 8 1944 318
Registration District No. _____ Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: DePaul Hospital
(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: 000
17
96

(a) State Missouri (b) County _____

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

(d) Street No. 1509a Agnes St.
(If rural, give location)

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

3. (a) PRINT FULL NAME Henry Steinkamp

3. (b) If veteran, name war: None 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 Amelia Steinkamp nee Kisker 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased: July 30, 1892
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 26th year 1944 hour 9:05 AM minute _____ M.

21. I hereby certify that I attended the deceased from 1940 to 8/25/44 19____; that I last saw him alive on 8/25/44 19____; and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>52</u>	<u>0</u>	<u>27</u>	hr. _____ min. _____

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

10. Usual occupation Shoe Cutter

11. Industry or business _____

MOTHER { 12. Name William Steinkamp

FATHER { 13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

14. Maiden name Anna Jones

15. Birthplace Calhoun Co. Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Amelia Steinkamp
(b) Address 1509a Agnes St.

17. (a) Burial (b) Date thereof 8/30/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cemetery

18. (a) Signature of funeral director Math Hermann & Son
(b) Address 2161 East Fair Ave

19. (a) AUG 29 1944 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension Duration 6 hours

Due to unknown 4 yrs plus?

Other conditions 83

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? _____

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

23. Signature J. M. O. Newley (M. D. or other) M.D.
Address 3633 Fair Ave Date signed 8/28/44

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 *Gustav W. Dietrich*

Licensed Embalmer No. *4329*

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.