

FILED NOV 19 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

Registrar's No. **8907**

1. PLACE OF DEATH:  
 (a) County St.  
 (b) City or town St. Louis Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution St. Anthony's Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 days  
(Specify whether  
 In this community Life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2239a Mc Nair  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Robert J. Steiner

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 single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 23, 1901  
(Month) (Day) (Year)

8. AGE: Years 43 Months 7 Days 26 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation pipe fitter

11. Industry or business Laclede Gas Light Co.

MOTHER FATHER {  
 12. Name John Steiner  
 13. Birthplace Missouri  
 14. Maiden name Margaret Mc Evoy  
 15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Edwin Steiner  
 (b) Address 5767 Delor

17. (a) Burial (b) Date thereof Oct. 23 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Thos Kutis & Son  
2906 Gravois Av.  
 (b) Address \_\_\_\_\_

19. (a) OCT 20 1944 (b) J. F. Bredsch  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 19  
 year 1944 hour 4 minute 30 PM

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to Oct. 19, 1944, 19\_\_\_\_; that I last saw him alive on Oct. 19, 1944, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis due to perforated Bowel

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

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

Duration  
1 day  
6 mo.  
 PHYSICIAN  
 \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

Major findings:  
 Of operations Peritonitis due to Perforated bowel  
 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) (a) Means of injury

23. Signature Dr. W. H. Walters M. D.  
 Address 3608 S. Grand Av. Date signed 10/20/44

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

**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.....

*David Van Horn*

Licensed Embalmer No. 4242

P. O. Address. 2906 Harrison

**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.**