

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 31 1945
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 812
Registrar's No. 661

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: Desloge Hospital
(d) Length of stay: In hospital or institution. 1-day
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Joseph Anthony Steitz
3. (b) If veteran, name war. No. 3. (c) Social Security No.

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.
6. (b) Name of husband or wife Amelia Steitz 6. (c) Age of husband or wife if alive 41 years
7. Birth date of deceased March 30th., 1902 (Month) (Day) (Year)

8. AGE: Years 42 Months 9 Days 10 If less than one day hr. min.

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

10. Usual occupation Clerk
11. Industry or business Loose-Wiles Biscuit Co.

12. Name John Steitz, MOTHER FATHER
13. Birthplace St. Louis Mo. U (City, town, or county) (State or foreign country)
14. Maiden name Mary McAuliffe
15. Birthplace St. Louis Mo. U (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Amelia Stietz
(b) Address 1424a Franklin Ave.

17. (a) Burial (b) Date thereof 1-24-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd.

19. (a) JAN 23 1945 (Date received local registrar) J. F. Brederek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 1424a Franklin Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 20th. year 1945 hour 10 minute 50 p. M.

21. I hereby certify that I attended the deceased from Jan. 16, 1945 to Jan. 20, 1945 that I last saw him alive on Jan. 20, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure (Congestive) 2 weeks
Due to Chronic Nephritis ?

Due to
Other conditions none 1/31
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations
Of autopsy
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 E. Lee Shroader (M. D. or other) Address 3720 Washington Date signed 1/22/45

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

1-3
2026146

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..... *W. Van Matre*

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

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.