

FILED OCT 14 1945

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
(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:
City Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
In this community 5 yr. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis City
(If outside city or town limits, write "RURAL")
(d) Street No. 3022 A. Kossuth Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Carl W. Steinbruegge

3. (b) If veteran, name war none 3. (c) Social Security No. 493-07-9856

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Marie Steinbruegge 6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased April 23 1902
(Month) (Day) (Year)

8. AGE: Years 43 Months 5 Days 9 If less than one day hr. _____ min _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Frank Steinbruegge
13. Birthplace Germany 4
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Marie Steinbruegge
(b) Address 3022 A. Kossuth Ave.
17. (a) Burial (b) Date thereof Oct. 6 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New Bethelhem Cem.

18. (a) Signature of funeral director Diedrich F. Home
(b) Address 8319 Halls Ferry Rd.

19. (a) OCT 5 1945 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 2
year 1945 hour 12:30 minute 15 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Arrhythmia due to coronary artery disease Duration _____
found in hospital in 1945
on the third floor at his home 3022 Kossuth Ave
St. Louis Mo
on Oct 5 1945 at about 11:50 AM

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

Major findings: Of operations 1/6th
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) suicide
(b) Date of occurrence Oct. 2 1945
(c) Where did injury occur? at home
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

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

23. Signature Patrick E. Taylor (M.D. or other) _____
Address Deputy Coroner Date signed 10-5-45

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

2.072
1-8-
X1

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. Wilkins

Licensed Embalmer No. 357

P. O. Address.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1102
Registrar's No. 8615

Registration District No. 318

Primary Registration District No. 1003

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:
(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

3. (a) PRINT FULL NAME Carl W. Steinbruegg

3. (b) If veteran, name war _____

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 _____

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

7. Birth date of deceased Apr 23 1906
(Month) (Day) (Year)

8. AGE: Years 42 | Months _____ | Days _____ | If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

{ 14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) NOV 13 1945 (b) J. F. Bredeck
(Date received) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day _____ year 1945 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration _____

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 _____ (M. D. or other) _____

Date signed _____

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

SUPPLEMENTARY

32413