

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **18939**

**FILED** MAY 31 1946  
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4556**

1. PLACE OF DEATH

(a) County.....  
(b) City or town..... **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Enroute to City Hospital** **3**  
(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 **Joseph E. Stein**

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 **June 22 1928**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**17 10 27**  
hr. min.

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

10. Usual occupation **Student McKinley High School**

11. Industry or business

MOTHER FATHER { 12. Name **Joseph Stein**  
13. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Anna Mahon**  
(City, town, or county) (State or foreign country)  
15. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Joseph E. Stein**  
(b) Address **3426a Illinois**  
17. (a) **Burial** (b) Date thereof **5/23/46**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Walter H. Hilde**  
(b) Address **3634 Gravois Ave.**  
19. (a) **MAY 21 1946** (b) **J. Z. Bruck**  
(Date received local registrar) (Registrar's signature)

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. **3426a Illinois Ave.**  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **19**  
year **1946** hour **12:25** minute **P** M.

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

Immediate cause of death.....  
**Subacute Endocarditis**

Due to.....  
Due to.....

..... conditions  
(Include pregnancy within 3 months of death)

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)  
(c) Means of injury.....  
23. Signature **Robert E. Taylor**  
Address.....  
Date signed **5/24/46**

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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 C. Wheeler

Licensed Embalmer No. 2178

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.**