

FILED SEP 9 1948

1003

Registration District No. **318**

Primary Registration District No. _____

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:
St. Louis City 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:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3105 Nebraska**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Adolph J. Steiner**

3. (b) If veteran, **N11** name war _____
3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Alma Steiner**
6. (c) Age of husband or wife if alive **69** years

7. Birth date of deceased **August 10 1877**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 11 19 hr. _____ min.

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

10. Usual occupation **Unemployed**

11. Industry or business _____

MOTHER FATHER { 12. Name **John Steiner**
13. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Gilbert Newberry**
(b) Address **3642a Tennessee**

17. (a) **Burial** (b) Date thereof **8-15-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus Cemetery**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **AUG 14 1948** (b) **J. F. Brasick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **29**
year **1946** hour **10** minute **40** 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: **Chronic Interstitial Nephritis**

Due to **Chronic Myocarditis**

Other conditions: **131**
(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 **Alfred J. Perry** (M. D. or other) **2**
Address **Deputy Coroner** Date signed **8-21-46**

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..... *J. Allen Davis*.....
Licensed Embalmer No..... *4063*.....

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.