

No. 2
12-45
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X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 15674
Registrar's No. 4693

FILED MAY 14 1947
Registration District No. 318

Primary Registration District No. _____

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

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:
5711 Theodosia Ave.
(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 Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5711 Theodosia Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME August J. Steinhauer
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 married
6. (b) Name of husband or wife Joetta Steinhauer
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased Oct. 4 1886
(Month) (Day) (Year)

8. AGE: Years 60 Months 7 Days 4
If less than one day _____ hr. _____ min.

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

10. Usual occupation Pattern Maker

11. Industry or business _____

MOTHER FATHER {
12. Name Joseph Steinhauer
13. Birthplace _____ Ky. /
(City, town, or county) (State or foreign country)
14. Maiden name Minnie Rath
15. Birthplace _____ Ky. /
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Joetta Steinhauer
(b) Address 5711 Theodosia Ave.

17. (a) Burial (b) Date thereof 5-12-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cem. Drehmann-Harral

18. (a) Signature of funeral director _____
(b) Address 1905 Union Blvd.

19. (a) MAY 9 1947 (b) J. F. Bredick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8
year 1947 hour 3 minute 45 A.M.
21. I hereby certify that I attended the deceased from Jan. 1, 47
1947 to May 6, 47
that I last saw him alive on May 6, 47
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary Occlusion
Coronary Atherosclerosis
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death) GH

Duration

1 day

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 J. M. ... (M. D. or other) Full
Address Hubert ... Date signed 5-19-47

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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..... *Albert R. Thompson Jr*

Licensed Embalmer No. *4237*

P. O. Address..... *St. Louis*

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.