

No. 2
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17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15676

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2796**

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:
St. Johns 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. **4230 W Margarettta Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **John H. Steudeman**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **Mamie Delaney Steudeman** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **April 4 1884**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	63	0	5	hr. _____ min. _____

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

10. Usual occupation **Maintenance Man**

11. Industry or business _____

12. Name **Unknown**

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 **Joseph Steudeman**

(b) Address **4230 W Farlin Ave.**

17. (a) **Burial** (b) Date thereof **4/12/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Stroot-Carroll**

(b) Address **4600 Natural Bridge Ave.**

19. (a) **1947** (Date received by registrar) (b) **J. F. Bredeek** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **9**
year **1947** hour _____ minute **P** M.

21. I hereby certify that I attended the deceased from **Dec 30,**
19**46** to **April 9**, 19**47**
that I last saw him **in** alive on **April 9**, 19**47**,
and that death occurred on the date and hour stated above.

Immediate cause of death **uremia of carcinoma of prostate**
Due to **carcinoma of prostate** 4 1/2 yrs

Other conditions **Diabetes mellitus** 6 mos.
(include pregnancy within 3 months of death)

Major findings: **Carcinoma of Prostate**
Of operations _____
Of autopsy _____

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 **fall**

23. Signature **Charles A. Anderson** (M. D. or other) **MD**
Address **609 Humboldt Bldg.** Date signed **4-10-47**

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

MOTHER FATHER

6

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

Ben Hoffman

Licensed Embalmer No.

4366

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.