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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 4 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33052

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9033

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: Barnes Hospital, O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 mo 11 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 200

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 6222 Fauquier Drive 9
(If rural, give location)

(e) Citizen of foreign country? 5 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Florence Belva Steiner

3. (b) If veteran, name war none

3. (c) Social Security No. NONE

4. Sex Female

5. Color or race W,

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Alfred Steiner

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased May (Month) 17 (Day) 1893 (Year)

8. AGE: Years 54 Months 4 Days ~~10~~ 11 If less than one day hr. min.

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

10. Usual occupation At home

11. Industry or business

MOTHER FATHER

12. Name David Rosenkranz

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

14. Maiden name Lena Jacobson

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

16. (a) Informant Alfred Steiner

(b) Address 6222 Fauquier Dr.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept, 30, 1947 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai

18. (a) Signature of funeral director Mayer

(b) Address 4356 Lindell Blvd

19. (a) SEP 29 1947 (Date received by local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28 year 1947 hour 2 minute 15 A. M.

21. I hereby certify that I attended the deceased from June 17, 1947, to Sept 28, 1947; that I last saw he alive on Sept 28, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure — Duration

Due to Brain tumor

Due to Metastasis from Carcinoma of the breast

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy As above

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature F. R. Bradley (M. D. or other)

Address Barnes Hospital, Date signed 9/28/47

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

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.