

No. 2
17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 24 1947
318

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

State File No. 36297
9423
Registrar's No.

Registration District No. 318 Primary Registration District No.

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: De Paul Hospital
(d) Length of stay: In hospital or institution
In this community years, months or days

3. (a) PRINT FULL NAME Lillian Steiger
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Victor
6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased Feb 22 1887
(Month) (Day) (Year)

8. AGE: Years 60 Months 7 Days 17
If less than one day hr. min.

9. Birthplace - Springfield Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife
11. Industry or business Home

MOTHER FATHER
12. Name William Atkinson
13. Birthplace England
14. Maiden name Unknown
15. Birthplace England

16. (a) Informant Mr. Victor Steiger
(b) Address 5475 Oriole
17. (a) Burial (b) Date thereof 10/13/47
(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director
(b) Address 3710 N. Grand Blvd.
19. (a) OCT 11 1947 (Date received local registrar)
J. F. Bradeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(d) Street No. 5475 Oriole
(e) Citizen of foreign country? No
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 9
year 1947 hour 7 minute 50 P.M.
21. I hereby certify that I attended the deceased from
1934/47 to October 9, 1947
that I last saw her alive on 7 October 1947
and that death occurred on the date and hour stated above.

Immediate cause of death shock
Due to trauma of surgery
Other conditions
Major findings: rupture of left ventricle
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?
(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. F. Bradeck (M. D. or other)
Address

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

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 Mayfield
Licensed Embalmer No. 3077

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.