

S. No. 300  
M-10-47  
ev. 5-17-39  
I 3906

FEDERAL BUREAU OF INVESTIGATION

National Office of Vital Statistics

FILED JUN 15 1948

Registration District No. 372

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

18316  
State File No.

Registrar's No. 1378

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Koch (rural)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Robert Koch Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1148 days  
(Specify whether years, months or days) 10 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4376a Enright  
(If rural, give location) 179  
(e) Citizen of foreign country? No (Yes or No) 1  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME STEELE, ELVATA

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 3 1924  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
23 9 18 hr. min.

9. Birthplace Golden Mississippi  
(City, town, or county) (State or foreign country)

10. Usual occupation Practical Nurse

11. Industry or business \_\_\_\_\_

12. Name James Steele

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

14. Maiden name Bea Wilson  
15. Birthplace Golden Mississippi  
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Robert Koch Hospital

17. (a) Burial (b) Date thereof 5-26-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Boyd Bros

(b) Address So. Kintoch 21 Mo

19. (a) 5-25-48 (b) Cecil G. Sharp MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21  
year 1948 hour 12 minute 27 A.M.

21. I hereby certify that I attended the deceased from 3-30-45, 1945 to 5-21-48, 1948;  
that I last saw her alive on 5-21-48, 1948;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration ??

Due to 13k

Due to \_\_\_\_\_

Other conditions 13k  
(Include pregnancy within 3 months of death)

Major findings:  
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? \_\_\_\_\_  
(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 Bernard Friedman MD (M. D. or other) MD

Address Robert Koch Hospital Date signed 5/21/48

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER, FATHER

**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 Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4548 1/2 Page Blvd

**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.

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