

FILED OCT 4 1948

Registration District No. **1948**Primary Registration District No. **1000**Registrar's No. **1017**

1. PLACE OF DEATH:

(a) County **Buchanan**
 (b) City or town **St. Joseph**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri Methodist Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **8 days** (Specify whether

In this community **Lifetime**
 years, months or days)

3. (a) PRINT FULL NAME **Betty Lou Steinmann**

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 **Robert E. Steinmann** 6. (c) Age of husband or wife if alive **31** years
 7. Birth date of deceased **December 31 1927**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
20	8	22		hr. min.

9. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)10. Usual occupation **Housewife**

11. Industry or business

12. Name **Ira Chambers**13. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)14. Maiden name **Maude Louise Kirschu**15. Birthplace **Unknown Iowa**
(City, town, or county) (State or foreign country)16. (a) Informant **Robert E. Steinmann**(b) Address **609 Kentucky St., St. Joseph, Mo.**17. (a) **Burial** (b) Date thereof **Sept. 24, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Memorial Park Cemetery**18. (a) Signature of funeral director **Walter Meierhoffer**(b) Address **1946 Colboun St., St. Joseph, Mo.**19. (a) **9-27-48** (b) **E. L. Jenkins**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
 (c) City or town **St. Joseph**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **609 Kentucky Street**
 (If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **23rd**
year **1948** hour **2** minute **30 A.** M.

21. I hereby certify that I attended the deceased from
June 24, 19**48** to **Sept. 23**, 19**48**
 that I last saw h. **61** alive on **Sept. 23**, 19**48**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Hepatitis, acute toxic** Duration **6 days**

Due to **Pregnancy** **9 mo.**

Due to **145**
 Other conditions **Ruptured Esophageal ulcer** **1 day**
 (Include pregnancy within 3 months of death)

Major findings: **Cesarian Section** PHYSICIAN

Of operations **Cesarian Section**
 Of autopsy **Hepatitis, Ruptured esophageal ulcer**
 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 **E. T. Bloomer** M. D. or other **M. D.**
Address **1218 N. 3rd St. Joseph, Mo.** signed **9/24/48**

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, ~~by~~.....

....., Registered Apprentice No.

working under my personal supervision.

Signed

Raymond A. Marcher

Licensed Embalmer No. 4413 Missouri

P. O. Address St. Joseph, 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.

2-1-1900