

7. S. No. 2
DOM-5-43
Rev. 5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41859**

FILED JAN 11 1949

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11289**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
17
19

1. PLACE OF DEATH:

(a) County **St Louis Mo**

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Missouri Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **10-15-48**
(Specify whether years, months or days) **To 12-26-48**

3. (a) PRINT FULL NAME **Ralph Steele**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **white**

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

6. (b) Name of husband or wife **Marie**

6. (c) Age of husband or wife if alive **46** years

7. Birth date of deceased **August 16 1895**
(Month) (Day) (Year)

8. AGE: Years **55** Months **4** Days **10**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **Bridgeman**

11. Industry or business **Steel**

MOTHER FATHER { 12. Name **UNKNOWN**

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

14. Maiden name **UNKNOWN**

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

16. (a) Informant **Springfield Missouri**

(b) Address _____

17. (a) **Burial** (b) Date thereof **12-29-1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Springfield Mo**

18. (a) Signature of **Ronald Mortuary Service**

(b) Address **4104 Manchester**

19. (a) **DEC 29 1948** (b) **J. B. Lasater**
(Date received and filed) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **39**

(c) City or town **Springfield** **2**
(If outside city or town limits, write "RURAL")

(d) Street No. **9185 Rf 3** **4**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **26**
year **1948** hour **8** minute **25 A.M.**

21. I hereby certify that I attended the deceased from **Oct. 15 1948** to **Dec 26 1948**
that I last saw him alive on **Dec 25 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **7. Hemorrhage from esophageal varix** **1 day**
Duration

Due to **cirrhosis of the liver**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **124**

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 **1**

23. Signature **Augustine Jones** (M. D. of _____)

Address **31 N. Belmont** Date signed **12-29-48**

JAN 25 1949

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64-12-51
31-12-51

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.....

E. Allen Davis

Licensed Embalmer No. 4053

P. O. Address Ph. L.

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.