

No. 300
-10-47
-17-39
3908

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42119
Registrar's No. 2797

FILED DEC 31 1948
Registration District No. _____

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution:
Robt Koch Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 229 days (Specify whether
Life (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis

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

(d) Street No. 4537 Shenendoah
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Harry J Steffen

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 2
year 1948 hour 7 minute P M.

4. Sex Male 0 5. Color or race White

6. (a) Single, widowed, married, divorced Divorced 3

6. (b) Name of husband or wife Edith Alt 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 22 1906
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4-13, 1948 to 12-2, 1948;
that I last saw him alive on 12-2, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis ?
Duration 6 mos

8. AGE: Years 42 Months 0 Days 10 days
If less than one day hr. _____ min.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

9. Birthplace St Louis Missouri 17
(City, town, or county) (State or foreign country)

10. Usual occupation Maintenance Man

11. Industry or business Quick Meal Stove Co

MOTHER FATHER

12. Name Jacob Steffen 0

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

14. Maiden name Anne Mohrman

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Hospital Records

(b) Address Koch Hospital Koch Mo

17. (a) Burial (b) Date thereof 12-6-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St Marcus

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? _____

18. (a) Signature of funeral director Kriegshausner Und So

(b) Address 4228 S Kingshighway St. Louis Mo

19. (a) 12/3/48 (b) Thurid V Lininger M D
(Date received local registrar) (Signature)

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Dr. John V. C...? (M. D. or other) 12-7

Address Robert Koch Hospital Date signed 12-3-48

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, 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.

No. 3908
-10-7
-17-39
1, 3908

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. **2797**

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Lock Mo

(c) Name of hospital or institution: Robert Red Hospital
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 225 days
(If not in hospital or institution, write street number or location) (Specify whether life)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 4537 Sherwood 94
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Henry J. STEFFEN

3. (b) If veteran, _____ name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 2
year 1948 hour 7 minute - Plum.

21. I hereby certify that I attended the deceased from 4-13-1948 to 12-2-1948
that I last saw him alive on 12-2-1948
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced div

6. (b) Name of husband or wife Edith Aet 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 22 1906
(Month) (Day) (Year)

Immediate cause of death Coronary Thrombosis Duration 6 weeks

Due to _____

Due to _____

8. AGE: Years 42 Months 0 Days 10 If less than one day _____ hr. _____ min.

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

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

10. Usual occupation Chain Keyance Man

11. Industry or business QUICK MEAL STOVE CO.

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER, FATHER { 12. Name Jacob Steffen

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

{ 14. Maiden name Anne Robinson

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

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? _____

16. (a) Informant hospital records

(b) Address Lock Mo

17. (a) BURIAL (b) Date thereof 12-6-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NEW ST. MARCUS CEM.

23. Signature Dr. John T. Kelsch (M.D. or other) _____
Address Robert Red Hospital Date signed 12/3-48

18. (a) Signature of funeral director KRIEGSHAUSER UND CO

(b) Address 4478 SO. KINGSHIGHWAY BL.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

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2000 12 10 20

1915 12 15

1911 - 5 12 1911
1911 - 5 12 1911

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 *Edwin A. McArthur*

Licensed Embalmer No. *3024*

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.

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2797

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____ years, months or days)
3. (a) PRINT FULL NAME Harry J. Steffen
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased mm 22 (Month) (Day) (Year)

8. AGE: Years 42 Months 0 Days 0 (Less than one day) hr. _____ min. _____
9. Birthplace _____ (City, town, or county) (State or foreign country) Mo

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)
18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 12-3-48 (b) Harold L. ... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

(52)-42119