

360
 48
 FILED SEP 9 1949
 X WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
 5/2
 3

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27767

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 655

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>"Rural" St. Charles Township</u>	
c. LENGTH OF STAY (In this place) <u>14 days</u>		d. STREET ADDRESS (If rural, give location) <u>R.R. 3 Box 139</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Anthony</u>	b. (Middle) <u>J.</u>	c. (Last) <u>Steinhoff</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>August 27 1949</u>
--	-----------------------	----------------------------	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 14, 1907</u>	9. AGE (In years last birthday) <u>42</u>	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Portage des Sioux, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Anton Steinhoff</u>	13b. MOTHER'S MAIDEN NAME <u>Claudine Conover</u>	14. NAME OF HUSBAND OR WIFE <u>Mildred (Sundermeier) Steinhoff</u>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL-SECURITY NO. <u>486-16-2516</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Mildred Steinhoff - St. Charles, Mo</u>
--	--	---

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) <u>acute cor pulmonale</u>	
DUE TO (c) <u>Chr. asthma</u>		<u>1 week</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>2 yrs.</u>	
<u>Infarct pt lung.</u> <u>Hypertensive heart disease</u>		<u>1 wk</u> <u>3 mos</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>442X</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/4/1947, to 8/27/1949, that I last saw the deceased alive on 8/27/1949, and that death occurred at 7:25 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>R. J. Sordie M.D.</u>	23b. ADDRESS <u>126 S. Main St. Charles, Mo</u>	23c. DATE SIGNED <u>8/29/49</u>
---	---	---

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug 31, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Portage des Sioux, Mo.</u>
---	---	--	---

DATE REC'D BY LOCAL REG. <u>8-31-49</u>	REGISTRAR'S SIGNATURE <u>Fannie Hamilton</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H. O. Dallenmeyer + Sons Co.</u> <u>800 N. 2nd - St. Charles, Mo.</u>
---	--	--

45 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
SEP 6 1919
District Health Officer No. 9,
District File Number

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 4189

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Joseph I. Landolt

Licensed Embalmer No. 4189

P. O. Address St Charles 2

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.