

FILED MAR 8 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

7034

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069 Registrar's No. 496

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u>	
c. LENGTH OF STAY (In this place) <u>1 year</u>		d. STREET ADDRESS (If rural, give location) <u>6420 Clayton Road</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>			

3. NAME OF DECEASED a. (First) <u>Sister Mary</u> (Type or Print)		b. (Middle) <u>Eulalia (Mary</u>		c. (Last) <u>Steinkrueger)</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 25 1950</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Sept. 23, 1866</u>	
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>5</u>		IF UNDER 1 YEAR Days <u>2</u>		IF UNDER 1 YEAR Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital Administrator</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>Peter Steinkrueger</u>		13b. MOTHER'S MAIDEN NAME <u>Barbara Hecker</u>		14. NAME OF HUSBAND OR WIFE <u>---</u>	
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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>---</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Sister Mary Servatia, S.S.M.</u>		ADDRESS <u>---</u>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) <u>Acute Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 hr</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Acute Pneumonia</u>				<u>14 Days</u>	
		DUE TO (c) <u>Cholecystitis</u>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Aspirin</u>					

19a. DATE OF OPERATION <u>---</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 Nov. 1948, 1948, to Feb. 25, 1950, that I last saw the deceased alive on Feb 23, 1950 and that death occurred at 10:15a m., from the causes and on the date stated above.

23a. SIGNATURE <u>James F. Wade M.D.</u>		23b. ADDRESS <u>1804 West 120th St</u>		23c. DATE SIGNED <u>2/25/50</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Feb 28-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem</u>		24d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>	
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DATE REC'D BY LOCAL REG. <u>2-26-50</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Donkey</u>		F. FUNERAL DIRECTOR'S SIGNATURE <u>W H Boekega</u>		ADDRESS <u>6536 Clayton Rd</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

4005
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed

Robert M. Murray

Licensed Embalmer No. *3749*

P. O. Address *St. Louis 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.