

FILED MAY 5 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15036

State File No. 3837  
Registrar's No. 1003

REG. DIST. NO. 318

PRIMARY REG. DIST. NO.

BIRTH NO.

REG. DIST. NO.

PRIMARY REG. DIST. NO.

Registrar's No.

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN **ST. LOUIS**

c. LENGTH OF STAY (In this place) ?

d. FULL NAME OF HOSPITAL OR INSTITUTION **DePaul Hospital**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE **MISSOURI** b. COUNTY

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **ST. LOUIS 9239**

d. STREET ADDRESS (If rural, give location) **75 1029 MARION 8**

3. NAME OF DECEASED

a. (First)

b. (Middle)

c. (Last)

d. DATE OF DEATH

(Month)

(Day)

(Year)

(Type or Print) **MISS LOUISE STEIN**

**4 24 50**

5. SEX

6. COLOR OR RACE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **NEVER MARRIED**

8. DATE OF BIRTH

9. AGE (In years last birthday) -- Months Days Hours Min.

**FEMALE**

**WHITE**

**8-9-25**

**74**

**7**

**0**

**0**

**0**

**0**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY **NONE**

11. BIRTHPLACE (State or foreign country) **MISSOURI**

12. CITIZEN OF WHAT COUNTRY? **U.S.**

13a. FATHER'S NAME

13b. MOTHER'S MAIDEN NAME

14. NAME OF HUSBAND OR WIFE

**C. E. Stein**

**Gertrude Peters**

**None**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS **Ned Stein 4045 Magnolia**

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **Hypertensive + Arteriosclerotic heart disease**

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause: (a) stating the underlying cause last. **Cerebral Thrombosis**

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

**7 days**

19a. DATE OF OPERATION **none**

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES  NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) **none**

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) **ST. LOUIS MO**

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **4-17**, 19**50**, to **4-24**, 19**50**, that I last saw the deceased alive on **4-23**, 19**50**, and that death occurred at **3:45 A.M.**, from the causes and on the date stated above.

22a. SIGNATURE

(Degree or title)

23b. ADDRESS

23c. DATE SIGNED

**Robert M. Louch D M.D.**

**De Paul Hosp.**

**4-25-50**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24b. DATE **4-27-1950**

24c. NAME OF CEMETERY OR CREMATORY **SS Peter & Paul**

24d. LOCATION (City, town, or county) (State) **St. Louis, Mo.**

DATE REC'D BY LOCAL REG. **APR 26 1950**

REGISTRAR'S SIGNATURE **[Signature]**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **Weick Bro. Und. Co. 2201 S. Grand**

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



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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 James R. Deane .....

Licensed Embalmer No. 4527 .....

P. O. Address 2201 S. Grand Bl. .....

**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.