

FILED FEB 16 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6691**
1064

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		f. STREET ADDRESS (If rural, give location) 4534 Washington Blvd.	

3. NAME OF DECEASED (Type or Print)	a. (First) Kenneth	b. (Middle) J.	c. (Last) Steibert	4. DATE OF DEATH (Month) (Day) (Year) Feb. 2, 1951
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 3	8. DATE OF BIRTH Nov. 13, 1903	9. AGE (In years last birthday) 47	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Stage Decorator	11. BIRTHPLACE (State or foreign country) Edwardsville, Ill.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME John L. Steibert	13b. MOTHER'S MAIDEN NAME Catherine Cavella	14. NAME OF HUSBAND OR WIFE Mildred
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Cecil Fischer	ADDRESS 4534 Washington
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ischemic Renovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 2 days 1 yr? 3 yrs?
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Esophageal Varix		
	DUE TO (c) Cirrhosis of liver		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 5810
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22. I hereby certify that I attended the deceased from **Feb 1, 1951**, to **Feb 2, 1951**, that I last saw the deceased alive on **Feb 2, 1951**, and that death occurred at **9:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John J. Corcoran M.D.	23b. ADDRESS 308 No. Grand	23c. DATE SIGNED 2/2/51
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24a. BURIAL - CREMATION REMOVAL (Specify) Burial	24b. DATE 2-5-51	24c. NAME OF CEMETERY OR CREMATORY Lake Charles	24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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DATE REC'D BY LOCAL REG. 2-2-51	REGISTRAR'S SIGNATURE J. B. Casar	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Murray

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.