

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25341**
Registrar's No. **6651**

FILED AUG 7 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 town OR TOWN St. Louis)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2159	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 4629 Alexander Ave.	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 4629 Alexander Ave.			

3. NAME OF DECEASED (Type or Print) Caroline Steinkamp			4. DATE OF DEATH (Month) (Day) (Year) July 23, 1951		
a. (First)		b. (Middle)		c. (Last)	

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 26, 1891	9. AGE (In years last birthday) 60	10. UNDER 1 YEAR Days 0	11. UNDER 1 MRS. Hours 27
----------------------	-------------------------------	---	---------------------------------------	---	--------------------------------	----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Jefferson County Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	-----------------------------------	---	--

13a. FATHER'S NAME James Mc Farland	13b. MOTHER'S MAIDEN NAME Not known	14. NAME OF HUSBAND OR WIFE Aloysius Steinkamp
--	--	---

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 Aloysius Steinkamp	ADDRESS 4629 Alexander Ave.
--	-------------------------	---	------------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Emphysema		2 wks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cancer of uterus & metastasis; leukemia DUE TO (c) and degenerative arthritis		35 yrs.
II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION No	19b. MAJOR FINDINGS OF OPERATION No	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
----------------------------------	--	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify) No	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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 114X
--	--	--

22. I hereby certify that I attended the deceased from **15-July-51**, to **7-23**, 19**51**, that I last saw the deceased alive on **7-23**, 19**51**, and that death occurred at **1 P** m., from the causes and on the date stated above.

23a. SIGNATURE Joseph Gaudin (Degree or title)	23b. ADDRESS 4914 Gravois	23c. DATE SIGNED 7-24-51
---	----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/26/51	24c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
---	--------------------------	---	--

DATE REC'D BY LOCAL REG. JUL 25 1951	REGISTRAR'S SIGNATURE J. B. Lester	25. FUNERAL DIRECTOR'S SIGNATURE John H. Gebken Sons	ADDRESS 2630 Gravois Ave.
---	---	---	----------------------------------

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

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 F. Gebken

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

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.