

FILED NOV 30 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39774
Registrar's No. 9039

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
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 Overland 425 X	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 2415 Goodale	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital			

3. NAME OF DECEASED (Type or Print) Lillian	a. (First)	b. (Middle)	c. (Last) Steiner	4. DATE OF DEATH (Month) (Day) (Year) Oct. 13, 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 6, 1883	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 10	IF UNDER 6 HRS. Days 7	IF UNDER 1 MIN. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Mt. Vernon New York	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Moir	13b. MOTHER'S MAIDEN NAME ?	14. NAME OF HUSBAND OR WIFE Bernard S. Steiner
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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. 490-10-6331A	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bernard S. Steiner 2415 Goodale
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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) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 5 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial Degeneration 3 yrs.		
	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 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)
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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? 4201
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22. I hereby certify that I attended the deceased from 10-7-1951, to 10-13-1951, that I last saw the deceased alive on 10-12-1951, and that death occurred at 3:45A m., from the causes and on the date stated above.

23a. SIGNATURE Herman J. Klotz (Degree or title) M.D.	23b. ADDRESS 9621 Laddland Rd.	23c. DATE SIGNED 10-14-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Oct. 15, 1951	24c. NAME OF CEMETERY OR CREMATORY St. Francis Cemetery	24d. LOCATION (City, town, or county) (State) Portage de Sioux Mo
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DATE REC'D BY LOCAL REG. OCT 15 1951	REGISTRAR'S SIGNATURE Paul Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE OR ADDRESS Ortman Funeral Home 9222 Lackland
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed Al C Ostmann

Signed.....
Student Embalmer

Licensed Embalmer No. 3478

P. O. Address _____

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.