

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **989**
Registrar's No. **40**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5466**

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Michigan b. COUNTY Wayne	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield; S. Campbell Rural		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Detroit	
c. LENGTH OF STAY (In this place) 5 mo. 5 d.		d. STREET ADDRESS (If rural, give location) Prisoners	
d. FULL NAME OF HOSPITAL OR INSTITUTION Medical Center for Federal Pr			

3. NAME OF DECEASED (Type or Print) a. (First) Max	b. (Middle) -----	c. (Last) Stephan	4. DATE OF DEATH (Month) (Day) (Year) Jan. 13, 1952
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 10, 1892	9. AGE (In years last birthday) 59	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Operator	11. BIRTHPLACE (State or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Johann Stephan	13b. MOTHER'S MAIDEN NAME Elizabeth Waltz	14. NAME OF HUSBAND OR WIFE Agnes Stephan
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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. Unknown	17. INFORMANT'S SIGNATURE OR NAME File-MCFP, Springfield, Missouri	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		
	ANTECEDENT CAUSES DUE TO (b) Adenocarcinoma of Sigmoid Colon DUE TO (c) Adenocarcinoma of Kidney (Metastatic) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION 9-11-51	19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of Sigmoid Colon	20. AUTOPSY? YES <input checked="" 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 type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that **The Medical Staff** attended the deceased from **8-8-**, 19**51**, to **Jan. 13**, 19**52**, that I last saw the deceased alive on **Jan. 13**, 19**52**, and that death occurred at **5:50 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE E. C. Rinok, M.D. (Degree or title)	23b. ADDRESS Medical Center for Federal Prisoners, Springfield, Mo.	23c. DATE SIGNED 1-14-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Jan. 15, 1952	24c. NAME OF CEMETERY OR CREMATORY Unknown	24d. LOCATION (City, town, or county) (State) New York City, New York
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DATE REC'D BY LOCAL REG. 1-14-52	REGISTRAR'S SIGNATURE James K. Amos	25. FUNERAL DIRECTOR'S SIGNATURE Ayre-Goodwin Fun'l Service, Spngfld.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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JAN 21 1952

APR 30 1952

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.

Signed.....
Student Embalmer

Signed Harry Ayre
Licensed Embalmer No. 4594
P. O. Address Springfield, 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.