

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30079

State File No. ....

FILED AUG 23 1952

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 7527

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY 2199	
b. CITY (If outside corporate limits, write RURAL and give town OR St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place) 34 Yrs		d. STREET ADDRESS (If rural, give location) 3831 Olive Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3831 Olive Street		19	
3. NAME OF DECEASED a. (First) Katherine b. (Middle) Steele c. (Last) Steele		4. DATE OF DEATH (Month) (Day) (Year) Aug. 6, 1952	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Nov. 14, 1883
9. AGE (In years last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Leo Schott		13b. MOTHER'S MAIDEN NAME Victoria Unknown	
14. NAME OF HUSBAND OR WIFE William Steele		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 ADDRESS Charles Kagels 4210 McPherson Ave.	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease ANTECEDENT CAUSES (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Portus Regurgitation DUE TO (c) 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"/>			
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)		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 4211	
22. I hereby certify that I attended the deceased from May 1, 1951, to Aug 6, 1952, that I last saw the deceased alive on May 15, 1952, and that death occurred at 6:30A m., from the causes and on the date stated above.			
23a. SIGNATURE Robert J. Farrell (Degree or title) M.D.		23b. ADDRESS 624 N. Union	
23c. DATE SIGNED 8/6/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-9-52	
24c. NAME OF CEMETERY OR CREMATORY Lakewood Park		24d. LOCATION (City, town, or county) St. Louis County (State)	
DATE REC'D BY LOCAL OFF. AUG 7 1952		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly		ADDRESS 3840 Wendell	

**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 \_\_\_\_\_

*W. A. Van Matre*

Licensed Embalmer No. 2825

P. O. Address 3840 Lindell

**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.