

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19934

State File No. ....

Registrar's No. 5007

 FILED JUN 4 1953  
 BIRTH NO. 4 1953

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

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

|   |  |  |   |  |  |  |
|---|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Missouri b. COUNTY Franklin |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis  |  | c. LENGTH OF STAY (In this place)  | c. CITY OR TOWN Washington  |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute City Hospital   |  |  | e. STREET ADDRESS (If rural, give location) 812 Edith St. 0362  |  |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) Lester  |  | b. (Middle) August   | c. (Last) Steinhaus   | 4. DATE OF DEATH (Month) (Day) (Year) May 16, 1953 |  |  |
| 5. SEX Male   | 6. COLOR OR RACE White   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married                   | 8. DATE OF BIRTH July 5, 1907   | 9. AGE (In years last birthday) 45                 | 10. UNDER 1 YEAR Months  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Worker   | 10b. KIND OF BUSINESS OR INDUSTRY Int. Shoe Co.  | 11. BIRTHPLACE (City and State or Foreign Country) Washington, Mo.               |   | 12. CITIZEN OF WHAT COUNTRY? U.S.                  |  |  |
| 13a. FATHER'S NAME Rudolph Steinhaus  |  | 13b. MOTHER'S MAIDEN NAME Lena Shoemeyer   |   | 14. NAME OF HUSBAND OR WIFE Patricia A. Steinhaus  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes   | 16. SOCIAL SECURITY NO. WW I 495-12-8614   | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Lester Steinhaus, Washington, Mo. ADDRESS |   |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.    |  |  | MEDICAL CERTIFICATION   |  |  |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last..  |  |  | DUE TO (b) Carotid Thrombosis   |  |  |  |
| DUE TO (c)  |  |  |   |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>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 checked="" type="checkbox"/> NO <input 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? 4201  |   |  |  |  |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:00 p.m., from the causes and on the date stated above. |  |  |   |  |  |  |
| 23a. SIGNATURE Patrick E. Taylor Coroner  |  | 23b. ADDRESS 1300 Clark  |   | 23c. DATE SIGNED 5-18-53                           |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal   | 24b. DATE 5-18-53  | 24c. NAME OF CEMETERY OR CREMATORY St. Francis Cemetery                          | 24d. LOCATION (City, town, or county) (State) Washington, Mo.   |  |  |  |
| DATE REC'D BY LOCAL REG. MAY 18 1953  | REGISTRAR'S SIGNATURE J. Carl Smith MD   |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.   |  |  |  |

(Licensed Embalmer's Statement on Reverse Side)

JUN 4 1953

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.....  
Signature of Student Embalmer

Signed *Ernest J. Garner*  
Licensed Embalmer No. *478*  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.