

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12885**BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **276** PRIMARY REG. DIST. NO. **5944** Registrar's No. **32**

1. PLACE OF DEATH a. COUNTY <b>Phelps</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO.</b> b. COUNTY <b>Phelps</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural</b>	c. LENGTH OF STAY (in this place) <b>20 yrs</b>	c. CITY OR TOWN <b>Rural</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ADAMANT JAMP.</b>		STREET ADDRESS (If rural, give location) <b>0870</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Ida</b> b. (Middle) <b>R.</b> c. (Last) <b>STEEN</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Apr. 30, 1955</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 11-1871</b>	9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR: Months <b>3</b> Days <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Centralia, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>Alan Breege</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Foster</b>	14. NAME OF HUSBAND OR WIFE <b>Middleton Steen</b>
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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) <b>—</b>	16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Logan Steen (son)</b>	ADDRESS <b>St. James, Mo.</b>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bronchial Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Indefinite</b>
	ANTECEDENT CAUSES <b>Arteriosclerosis</b>		
	DUE TO (b) <b>—</b>		
	DUE TO (c) <b>—</b>		
	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?
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22. I hereby certify that I attended the deceased from **9-19**, 19**53**, to **4-30**, 19**55**, that I last saw the deceased alive on **3-8**, 19**55**, and that death occurred at **6:00 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Josh. Grackreutz MD</b>	23b. ADDRESS <b>St. James, Mo</b>	23c. DATE SIGNED <b>May 2-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>May 2, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cem (Forest)</b>	24d. LOCATION (City, town, or county) (State) <b>St. James, Phelps MO.</b>
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DATE REC'D BY LOCAL REG. <b>5-5-1955</b>	REGISTRAR'S SIGNATURE <b>Ruth B. Powell 479</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Oral E. Licklider</b>	ADDRESS <b>St. James, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

FILED MAY 10 1955

0810

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 ME, Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Crae E. Licklider

Licensed Embalmer No. 356

P. O. Address St. John

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.