

Health, Welfare, Public Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED NOV 29 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39833

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10358**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Saint Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR ST. INSTITUTION <b>St. Louis City Hospital #1</b>			4. STREET ADDRESS <b>4038 Cleveland Ave.,</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>L.</b> Last <b>Steube</b>			4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 21st, 1882</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mr. Elmer Steube, 4232a Kossuth Avenue, 15</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of cerebral Artery</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last, DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>332 x H</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Carcinoma of mouth</b>					INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b> <b>40 yrs.</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>11-3-56</b> to <b>11-11-56</b> and last saw her <del>her</del> <b>her</b> alive on <b>11-11-56</b> Death occurred at <b>8:15p</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Physician or life) <b>John W. Stuzich M.D.</b>			22b. ADDRESS <b>1515 Lafayette</b>		22c. DATE SIGNED <b>11/13/56</b>
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11/14/56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
24. FUNERAL DIRECTOR <b>CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., FUNERAL HOME, INC., St. Louis, 15, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 13 1956</b>		26. REGISTRAR'S SIGNATURE <b>John W. Stuzich M.D.</b> <b>mll</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

Student.....  
Signature of Student Embalmer

Signed..... *Ralph C. Zindler* .....

Licensed Embalmer No. 42

P. O. Address..... *St. Louis* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.