

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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 21 1957

38191
STATE FILE NUMBER
9310
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

| | | | | | | | | |
|--|---------------------------|---|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp. | | Length of stay in lb 1 month | | d. STREET ADDRESS 3808 Castleman (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First CLARA Middle L Last STEIDEMANN | | | | 4. DATE OF DEATH Month Day Year October 4th, 1957 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 29, 1874 | | 9. AGE (In years last birthday) 82 | IF UNDER 1 YEAR Months Days Hours Min. 9 5 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instructor | | 10b. KIND OF BUSINESS OR INDUSTRY Deaf People | | 11. BIRTHPLACE (City and state or country) St. Louis, Missokri | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Martin Steidemann | | | | 14. MOTHER'S MAIDEN NAME Mary Ann Wilshusen | | | | |
| 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 Address Albert E. Steidemann 7445 Teasdale | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Colon with Perforation</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRINCIPAL DISEASE CONDITION GIVEN IN PART I (a) <i>153x</i> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>1 week about 2 wks</i> | |
| 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.) <i>---</i> | | | | | |
| 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 <i>9/1/56</i> to <i>10/4/57</i> and last saw <i>her</i> alive on <i>10/4/57</i> Death occurred at <i>2:35 P</i> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <i>Robert S Warner M.D.</i> (Degree or title) | | | | 22b. ADDRESS <i>818 Olive St St Louis Mo</i> | | 22c. DATE SIGNED <i>Oct 5-57</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 10/8/57 | 23c. NAME OF CEMETERY OR CREMATORY New St. Marcus | | 23d. LOCATION (City, town, or county) (State) St. Louis, Missouri | | | |
| 24. FUNERAL DIRECTOR ADDRESS C. R. Lupton & Sons 7233 Delmar | | | 25. DATE RECD. BY LOCAL REG. OCT 7 57 | | 26. REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i> J.P. | | | |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Brown Building
Chestnut 1-4747
Hours 11:30 To 3:00 P.M.
818 Olive

NOV 29 1957

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 *Arnold W. Schoene*

Licensed Embalmer No. 386

P. O. Address *St. Louis,*

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