

Health, Welfare
Public Service

FILED FEB 14 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3647

STATE FILE NUMBER

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

728

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
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 University City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 27 6500 Crest Ave.
3. NAME OF DECEASED (Type or print) First Middle Last William S. Steele			4. DATE OF DEATH Month Day Year 1 18 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City collector		10b. KIND OF BUSINESS OR INDUSTRY U. City, Mo.	9. AGE (In years last birthday) 87
11. BIRTHPLACE (City and state or country) Ky.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Richard Steele		13b. MOTHER'S MAIDEN NAME Marie Dowd	14. NAME OF HUSBAND OR WIFE Deceased
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO None		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Edward Reilly 6500 Crest Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Pulmonary Congestion - Stasis DUE TO (c) Intertrochanteric fracture @ Femur, Inactive Pulmonary Tbc			INTERVAL BETWEEN ONSET AND DEATH E904.7 45
20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Fall at Mt. St. Rose Hospital	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 12 5 57		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Mt. St. Rose Hospital		20f. CITY, TOWN OR LOCATION COUNTY STATE St. Louis Co. Mo.	
21. I attended the deceased from Dec 6, 1957 to Jan 18, 1958 and last saw him alive on Jan 18, 1958 Death occurred at 5:55 Pm on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) David Handler, m.d.		22b. ADDRESS 1325 South Grand	22c. DATE SIGNED 1-20-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-22-1958	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Missouri
24. FUNERAL DIRECTOR ADDRESS Jos. W. Clark F.H. 1125 Hodiament		25. DATE RECD. BY LOCAL REG. JAN 21 '58	26. REGISTRAR'S SIGNATURE Paul Smith MD m 98

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Robert M. Murray*
Licensed Embalmer No. *3749*
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.